Cigna®

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Entyvio
(vedolizumab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			**Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.**		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested: ☐ Entyvio 300mg vial

Dose and Quantity: Duration of therapy: J-Code:

Frequency of administration: ICD10:

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples of **Entyvio**, please choose "new start of therapy". ☐ new start of therapy ☐ continued therapy

If continued therapy:
(if Crohn's, continued therapy) Is there documentation your patient has had a beneficial response with the requested medication? Examples of beneficial response for Crohn's Disease include: decreased pain, fatigue, stool frequency, and/or blood in stool; or improvement via fecal markers (such as, fecal lactoferrin, fecal calprotectin), serum markers (such as, C-reactive protein), imaging studies (magnetic resonance enterography [MRE], computed tomography enterography [CTE]), endoscopic assessment, and/or reduced dose of corticosteroids. ☐ Yes ☐ No

(if UC, continued therapy) Is there documentation your patient has had a beneficial response to the requested medication? Examples of beneficial response for Ulcerative Colitis include decreased pain, fatigue, stool frequency, and/or decreased rectal bleeding; or improvement via fecal markers (such as, fecal calprotectin), serum markers (such as, C-reactive protein), endoscopic assessment, and/or reduced dose of corticosteroids. ☐ Yes ☐ No

(if no) Please provide clinical support for the continued use of **Entyvio**:

Which applies to your patient?
☐ patient is established on this drug with previous approval by Cigna for 30 days only
☐ patient is established on this drug with previous approval by Cigna for 12 months or more

Please provide the dates your patient has received **Entyvio**:

Besides the drug being requested, other biologics or targeted synthetic disease-modifying antirheumatic drugs (DMARDs) include Actemra, Adbry, Cibinqo, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Infliximab (Avsola, Inflectra, Remicade, Renflexis), Kevzara, Kineret, Olumiant, Orencia, Otezla, Rinvoq, Rituximab (Riabni, Rituxan, Rituxan Hycela, Ruxience, Truxima), Siliq, Simponi Aria, Simponi, Skyrizi, Stelara, Taltz, Tremfya, Tysabri, Xeljanz, Xeljanz XR, Zeposia. Which of the following best describes your patient's situation?

☐ The patient is NOT taking any other biologic or targeted synthetic DMARD at this time, nor will they in the future. The requested drug is the only biologic or targeted synthetic DMARD the patient is/will be using.
☐ The patient is currently on another biologic or targeted synthetic DMARD, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on another biologic or targeted synthetic DMARD, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another biologic or targeted synthetic DMARD.
☐ other/unknown

(if other/more than Entyvio) Please provide name of drug, dates taken and, if applicable, the clinical rationale for the combined use of Entyvio and another biologic/targeted synthetic DMARD to treat your patient's diagnosis.

(Please note: there are different preferred products depending on your patient's plan. Please refer to the applicable Cigna health care professional resource [e.g. cignaforhcp.com] to determine benefit availability and the terms and conditions of coverage)

Where will this medication be obtained?

☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?

☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use (please specify):

☐ Crohn's disease (CD) ☐ ulcerative colitis (UC) ☐ Other:_____

Does your patient have moderate to severe disease? ☐ Yes ☐ No

Clinical Information:

Is the requested medication being prescribed by (or in consultation with) a gastroenterologist? ☐ Yes ☐ No

If ulcerative colitis:

Has the patient already tried a biologic or targeted synthetic DMARD (tsDMARD) for Ulcerative Colitis? ☐ Yes ☐ No

Does your patient have Pouchitis? ☐ Yes ☐ No

(if yes) Has your patient tried therapy with an antibiotic (for example, metronidazole, ciprofloxacin), corticosteroid (enema or suppository), or mesalamine (enema or suppository)? ☐ Yes ☐ No

The covered alternative is ONE conventional systemic therapy. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if UC, no biologic) Per the information provided above, which of the following is true for your patient in regards to the covered alternative?

☐ The patient tried the alternative, but it didn't work well enough
☐ The patient is able to try the alternative, but has not done so yet
☐ The patient tried the alternative, but they did not tolerate it
☐ The patient cannot try the alternative because of a contraindication to it
☐ Other: Please specify_____

If Crohn's:

Has the patient already received a biologic for their condition? ☐ Yes ☐ No

Will vedolizumab (Entyvio) be taken concurrently with a corticosteroid? ☐ Yes ☐ No

Will vedolizumab (Entyvio) be taken concurrently with a conventional systemic therapy? ☐ Yes ☐ No

The covered alternatives are either a corticosteroid or a conventional systemic therapy. For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

Per the information provided above, which of the following is true for your patient in regards to the covered alternatives?
☐ The patient tried one of the alternatives, but it didn't work well enough
☐ The patient tried one of the alternatives, but they did not tolerate it
☐ The patient cannot try one of these alternatives because of a contraindication to this drug
☐ Other

Does your patient have any of the following?
☐ Severe disease needing hospitalization
☐ Involvement of the upper GI tract
☐ Smoker
☐ Less than 40 years of age
☐ Stricturing disease
☐ Perianal disease
☐ Other enterocutaneous fistula
☐ Extraintestinal manifestations (ankylosing spondylitis, pyoderma gangrenosum, erythema nodosum)
☐ Previous Crohn's disease-related surgery (for example, ileocolonic resection to reduce the chance of Crohn's disease recurrence)
☐ Bowel obstruction
☐ History of abscess or perforation (after healing)
☐ None of the above

Additional pertinent information: *Please provide any additional pertinent clinical information, including: alternatives tried and any reason(s) alternatives cannot be tried; if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (samples, out of pocket, etc).*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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