



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:

Has your patient had a good response to therapy with this drug (such as improvement or remission)? 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 6 months or more
- patient is established on this drug with previous approval by another health plan
- patient is established on this drug with regular use for more than 1 year
- patient was previously established on this drug, and is restarting after a break in therapy

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

Besides the drug being requested, other biological drugs include Actemra, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Olumiant, Orenzia, Otezla, Remicade, Renflexis, Rinvoq, Rituxan, Siliq, Simponi/Simponi Aria, Stelara, Taltz, Tremfya, Tysabri, Xeljanz/Xeljanz XR. Which of the following best describes your patient's situation?

- The patient is NOT taking any other biological at this time, nor will they in the future. **Entyvio** is the only biological the patient is/will be using.
- The patient is currently on another biological, but this drug will be stopped and **Entyvio** will be started.
- The patient is currently on another biological, and **Entyvio** will be added. The patient may continue to take both drugs together.
- The patient is currently on BOTH **Entyvio** AND another biological.
- 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 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**
- Prescriber's office stock (billing on a medical claim form)
- Other (please specify):

- Retail pharmacy
- Home Health / Home Infusion vendor
- *Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 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): _____

NOTE: Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting

Is this infusion occurring in a facility affiliated with hospital outpatient setting? Yes No

If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option 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:

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

If ulcerative colitis:

Is there documentation that your patient either has failure, inadequate response or intolerance OR has a contraindication per FDA label OR is not a candidate for any of the following conventional therapies?

- aminosalicylates (like Colazal, Dipentum, mesalamine, sulfasalazine)
- corticosteroids (like prednisone, budesonide, hydrocortisone)
- immunosuppressants (like azathioprine, mercaptopurine, methotrexate, cyclosporine)
- none of the above

Is this drug being prescribed by, or in consultation with, a gastroenterologist or a prescriber who specializes in ulcerative colitis? Yes No

If Crohn's:

Does the patient have moderate to severe disease? Yes No

Does the patient have documented failure or inadequate response, contraindication per FDA label, intolerance, is not a candidate for a corticosteroid OR will your patient take this drug concurrently with a corticosteroid (for example, prednisone, methylprednisolone)? Yes No

Does the patient have documented failure or inadequate response, contraindication per FDA label, intolerance, or is not a candidate for one conventional systemic therapy OR will your patient take this drug concurrently with a conventional systemic therapy (for example, azathioprine, 6-mercaptopurine, methotrexate [MTX])? Yes No

Is this drug being prescribed by, or in consultation with, a gastroenterologist or a prescriber who specializes in Crohn's disease? Yes No

Additional pertinent information: Please include any alternatives tried, with drug name, 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.

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:** _____

Save Time! Submit Online at: www.covermy meds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

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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