Entyvio Pen (subcutaneous)
(vedolizumab)

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

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 108 MG/0.68 ML pen

Dose Frequency of therapy: Duration of therapy:

J-Code: ICD10:

Describe the medication's current place in therapy for this patient.
☐ Initial Therapy (brand new start)
☐ Patient is currently receiving Entyvio subcutaneous or intravenous and has been established on it for at least 6 months.
☐ Patient is currently receiving Entyvio subcutaneous or intravenous and has been established on it for less than 6 months.
☐ Patient is restarting therapy with Entyvio subcutaneous or intravenous.

(If currently receiving Entyvio subcutaneous or intravenous and has been established on it for at least 6 months):

When assessed by at least one objective measure, did the patient experience a beneficial clinical response from baseline (prior to initiating the requested medication)? Examples of assessment for inflammatory response include fecal markers (for example, fecal calprotectin), serum markers (for example, C-reactive protein), endoscopic assessment, and/or reduced dose of corticosteroids. ☐ Yes ☐ No

Compared with baseline (prior to initiating the requested drug), did the patient experience an improvement in at least one symptom, such as decreased pain, fatigue, stool frequency, and/or decreased rectal bleeding? ☐ Yes ☐ No

(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):

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):

☐ ulcerative colitis (UC) ☐ Other:_____

Clinical Information:

Besides the medication being requested, other biologics and tsDMARDs (targeted synthetic disease-modifying antirheumatic drugs) include Actemra, adalimumab (Humira and all biosimilars), Cibinqo, Cimzia, Cosentyx, Enbrel, Ilumya, infliximab (Remicade and all biosimilars), Kevzara, Kineret, Olumiant, Omvoh, Orencia, Otezla, Rinvoq, rituximab (Rituxan and all biosimilars), Siliq, Simponi Aria, Simponi/Simponi Aria, Skyrizi, Sotyktu, Stelara, Taltz, Tremfya, Velsipity, Xeljanz/XR, Zeposia, Zymfentra. Which of the following best describes your patient's situation?

☐ The patient is NOT taking any other biologic or tsDMARD at this time, nor will they in the future. The requested drug is the only biologic or tsDMARD the patient is/will be using.
☐ The patient is currently on another biologic or tsDMARD, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on another biologic or tsDMARD, 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 tsDMARD.
☐ Other/unknown

Please provide the rationale for concurrent use.

(if initial therapy, restarting therapy, or currently receiving and established less than 6 months) According to the prescriber, is the patient currently receiving Entyvio intravenous or will the patient receive induction dosing with Entyvio intravenous within 2 months of initiating therapy with Entyvio subcutaneous? ☐ Yes ☐ No

(if initial therapy, restarting therapy, or currently receiving and established less than 6 months) Has the patient had a trial of one OTHER biologic for ulcerative colitis such as adalimumab SC products (Humira and biosimilars), infliximab IV products (Remicade, biosimilars), Simponi SC, Stelara? ☐ Yes ☐ No

(if yes) Please provide the name/names of the biologic(s) used.

(if no) Has the patient had a trial of ONE systemic therapy for ulcerative colitis (examples include 6-mercaptopurine, azathioprine, cyclosporine, tacrolimus, or a corticosteroid such as prednisone or methylprednisolone)? Note that a trial of a mesalamine product does not count as a systemic therapy for ulcerative colitis. ☐ Yes ☐ No

(if yes) Please provide drug name/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.

(if no) Does the patient have pouchitis? ☐ Yes ☐ No

(if pouchitis) Has the patient tried any of the following: an antibiotic (examples include metronidazole and ciprofloxacin), a probiotic, corticosteroid enema (an example is hydrocortisone enema), or mesalamine enema? ☐ Yes ☐ No

(if initial therapy, restarting therapy, or currently receiving and established less than 6 months) Is the requested medication prescribed by (or in consultation with) a gastroenterologist? ☐ Yes ☐ No

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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