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:

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

What is the indication or diagnosis?
☐ Crohn's disease
☐ ulcerative colitis (UC)
☐ Other (please specify):

Clinical Information:

Will the requested medication be used in combination with a BIOLOGIC or with a targeted synthetic oral small molecule drug?
☐ Biologic (an adalimumab product [Humira, biosimilar], Bimzelx, Cimzia, Cosentyx (IV or SC), etanercept SC product [Enbrel, biosimilar], Entyvio (IV), Ilumya, infliximab IV products [Remicade, biosimilar], Kevzara, Kineret, Omvoh (IV or SC), Orencia [IV or SC], a rituximab IV product [Rituxan, biosimilar], Skyrizi (IV or SC), Siliq, Simponi [Aria or SC]), an ustekinumab product [Stelara, biosimilar (IV or SC)], Taltz, a tocilizumab product [Actemra (IV or SC), biosimilar], Tremfya (IV or SC), or Zymfentra.
☐ Targeted synthetic oral small molecule drug (such as Cibinqo, Leqselvi, Litfulo, Sotyktu, Olumiant, Otezla, Rinvoq, Rinvoq LQ, Xeljanz, Xeljanz XR, Velsipity, or Zeposia.)
☐ Conventional synthetic DMARD (such as methotrexate, leflunomide, sulfasalazine, hydroxychloroquine)
☐ No, the requested medication will NOT be used in combination with another BIOLOGIC or Targeted Synthetic oral small molecule drug

Is this medication being prescribed by or in consultation with a gastroenterologist? ☐ Yes ☐ No

If Crohn's Disease:

Is the patient currently receiving Entyvio intravenous or subcutaneous? ☐ Yes ☐ No

Has the patient already received at least 6 months of therapy with Entyvio (IV or SC)? Please Note: Answer No if the patient has received less than 6 months of therapy or if the patient is restarting therapy with Entyvio (IV or SC). ☐ Yes ☐ No

When assessed by at least one objective measure, has the patient experienced a beneficial clinical response from baseline (prior to initiating the requested drug)? - Please Note: Examples of objective measures include fecal markers (for example, fecal lactoferrin, fecal calprotectin), serum markers (for example, C-reactive protein), imaging studies (magnetic resonance enterography [MRE], computed tomography enterography [CTE]), endoscopic assessment, and/or reduced dose of corticosteroids. ☐ Yes ☐ No

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

According to the prescriber, is the patient currently on Entyvio intravenous or will be receiving induction with Entyvio intravenous within 2 months of initiating therapy with Entyvio subcutaneous? Please Note: If the patient has already received this induction dose with Entyvio IV prior to starting Entyvio SC, please answer yes to this question. ☐ Yes ☐ No

Has the patient tried systemic corticosteroids, or the patient is currently on systemic corticosteroids, or are corticosteroids contraindicated in this patient? Please Note: Examples of corticosteroids: methylprednisolone, prednisone. ☐ Yes ☐ No

Has the patient tried one conventional systemic therapy for Crohn's disease? - Please Note: Examples of conventional systemic therapy for Crohn's disease include azathioprine, 6-mercaptopurine, or methotrexate. A trial of mesalamine does not count as a systemic therapy for Crohn's disease. ☐ Yes ☐ No

Has the patient had a trial of a biologic for Crohn's disease? Please Note: Examples include an adalimumab product (for example, Humira, biosimilars), an infliximab product (Remicade, biosimilars), Simponi SC, an ustekinumab product (Stelara, biosimilars). A biosimilar of the requested biologic does not count. ☐ Yes ☐ No

Does the patient have enterocutaneous (perianal or abdominal) or rectovaginal fistulas? ☐ Yes ☐ No

Has the patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence)? ☐ Yes ☐ No

If Ulcerative colitis:

Is the patient currently receiving Entyvio intravenous or subcutaneous? ☐ Yes ☐ No

Has the patient already received at least 6 months of therapy with Entyvio (IV or SC)? Please Note: Answer No if the patient has received less than 6 months of therapy or if the patient is restarting therapy with Entyvio (IV or SC). ☐ Yes ☐ No

When assessed by at least one objective measure, has the patient experienced a beneficial clinical response from baseline (prior to initiating the requested drug)? Please Note: 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), has the patient experienced an improvement in at least one symptom, such as decreased pain, fatigue, stool frequency, and/or decreased rectal bleeding? ☐ Yes ☐ No

According to the prescriber, is the patient currently on Entyvio intravenous or will be receiving induction with Entyvio intravenous within 2 months of initiating therapy with Entyvio subcutaneous? Please Note: If the patient has already received this induction dose with Entyvio IV prior to starting Entyvio SC, please answer yes to this question. ☐ 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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