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

Entyvio vial (intravenous)
(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 and schedule: 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):

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

What is the indication or diagnosis?

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

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 (SC), 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]), Taltz, a tocilizumab product [Actemra (IV or SC), biosimilar], Tremfya (IV or SC), an ustekinumab product (Stelara [IV or SC], biosimilars), 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 the requested 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 intravenous or subcutaneous? Please Note: Answer No if the patient has received less than 6 months of therapy or if the patient is restarting therapy with Entyvio intravenous or subcutaneous. ☐ 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 medication)? 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 receiving the requested medication), 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

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 tried at least one biologic other than the requested drug for Crohn's disease? A biosimilar of the requested biologic does not count. Please Note: Examples include adalimumab SC products (Humira, biosimilars), Cimzia, an infliximab product (Remicade, Zymfentra, biosimilars), Omvoh, Skyrizi, Tremfya, or an ustekinumab product (Stelara [IV or SC], biosimilars). ☐ 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 intravenous or subcutaneous? Please Note: Answer No if the patient has received less than 6 months of therapy or if the patient is restarting therapy with Entyvio intravenous or subcutaneous. ☐ 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 medication)? 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 receiving the requested medication), 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

Additional pertinent information:

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.covermymeds.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.

v090125