



Entyvio® Prior Authorization Request Form

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below: <input type="checkbox"/> Moderately to severely active Crohn's disease <input type="checkbox"/> Moderately to severely active Ulcerative colitis <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical information: Select if the requested medication is prescribed by or in consultation with one of the following specialists: <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Other _____ Will the requested medication be used in combination with another biologic agent or targeted immunomodulator? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For moderately to severely active Crohn's disease, also answer the following: Has the patient had an inadequate response to, intolerance to, or contraindication to one or more conventional therapies: azathioprine, 6-mercaptopurine, methotrexate, corticosteroids (e.g., prednisone, methylprednisolone) <input type="checkbox"/> Yes <input type="checkbox"/> No List _____					
For moderately to severely active ulcerative colitis, also answer the following: Has the patient had an inadequate response to, intolerance to, or contraindication to conventional therapy with one or more of the following: corticosteroids (i.e., prednisone, methylprednisolone), 5-ASAs (i.e., mesalamine, sulfasalazine, balsalazide, olsalazine), non-biologic DMARDs (i.e., azathioprine, methotrexate, mercaptopurine)? <input type="checkbox"/> Yes <input type="checkbox"/> No List _____					
Quantity limit requests: What is the quantity requested per TREATMENT? _____ syringe every _____ weeks					
What is the reason for exceeding the plan limitations? <input type="checkbox"/> Titration or loading dose purposes <input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime) <input type="checkbox"/> Requested strength/dose is not commercially available <input type="checkbox"/> Other: _____					

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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