



## Entyvio

### Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_

**Referring Provider Info:**  Same as Requesting Provider

**Name:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Fax:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Rendering Provider Info:**  Same as Referring Provider  Same as Requesting Provider

**Name:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Fax:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

*Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.*

**Required Demographic Information:**

*Patient Weight:* \_\_\_\_\_ kg

*Patient Height:* \_\_\_\_\_ cm

**Site of Service Questions (SOS):**

- A. Where will this drug be administered?
- |   |   |
|---|---|
| <input type="checkbox"/> Ambulatory surgical, <i>skip to Clinical Questions</i> | <input type="checkbox"/> Home infusion, <i>skip to Clinical Questions</i> |
| <input type="checkbox"/> Off-campus Outpatient Hospital                         | <input type="checkbox"/> On-campus Outpatient Hospital                    |
| <input type="checkbox"/> Physician office, <i>skip to Clinical Questions</i>    | <input type="checkbox"/> Pharmacy, <i>skip to Clinical Questions</i>      |
- B. Is this request to continue previously established treatment with the requested medication?
- Yes – This is a continuation of an existing treatment
- No – This is a new therapy request (patient has not received requested medication in the last 6 months) *skip to Clinical Criteria Questions*
- C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, or other pre-medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? **ACTION REQUIRED: Attach supporting clinical documentation.**
- Yes, *skip to Clinical Criteria Questions*  No

**Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720**

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- D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?  
**ACTION REQUIRED: Attach supporting clinical documentation.**  
 Yes, skip to Clinical Criteria Questions  No
- E. Has the patient previously experienced a severe adverse event during or immediately after an infusion including but not limited to: anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures?  
**ACTION REQUIRED: Attach supporting clinical documentation.**  
 Yes, skip to Clinical Criteria Questions  No
- F. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? **ACTION REQUIRED: Attach supporting clinical documentation.**  
 Yes, skip to Clinical Criteria Questions  No
- G. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?  
**ACTION REQUIRED: Attach supporting clinical documentation. Indicate and continue to Clinical Criteria Questions**  Yes  No

**Criteria Questions:**

1. Has the patient been diagnosed with any of the following?  
 Moderately to severely active Crohn's disease (CD)  
 Moderately to severely active ulcerative colitis (UC)  
 Immune checkpoint inhibitor-related diarrhea or colitis  
 Other \_\_\_\_\_
2. What is the ICD-10 code? \_\_\_\_\_
3. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Xeljanz)?  Yes  No
4. Is the patient currently receiving Entyvio?  Yes  No
5. What is the prescribed dose? Indicate mg and frequency.  
 Loading dose (if applicable) \_\_\_\_\_  
 Maintenance dose \_\_\_\_\_
6. Is this request for continuation of therapy with the requested drug?  
 Yes  No *If No, skip to diagnosis section.*
7. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to diagnosis section.*  Yes  No  Unknown
8. Has the patient achieved or maintained remission? **ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of remission.** *If Yes, no further questions*  Yes  No
9. Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?  
 Yes  No
10. *If diagnosis is ulcerative colitis (UC) or Crohn's disease (CD),* which of the following has the patient experienced an improvement in from baseline? **ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response to therapy.**

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Indicate ALL that apply.

- Stool frequency
- Rectal bleeding
- Urgency of defecation
- C-reactive protein (CRP)
- Fecal calprotectin (FC)
- Endoscopic appearance of the mucosa
- Improvement on a disease activity scoring tool (e.g., Ulcerative colitis Endoscopic Index of Severity [UCEIS], Mayo Score)
- None of the above

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Ulcerative Colitis

11. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Xeljanz) indicated for the treatment of moderately to severely active ulcerative colitis? **ACTION REQUIRED: If Yes, please attach patient's chart notes, medical record documentation, or claims history of previous medications tried.** If Yes, no further questions  Yes  No
12. Has the patient been hospitalized for acute, severe ulcerative colitis (e.g., continuous bleeding, severe toxic symptoms, including fever and anorexia)? **ACTION REQUIRED: If Yes, please attach supporting chart notes or medical record documentation of hospitalization due to acute, severe ulcerative colitis.** If Yes, no further questions  Yes  No
13. Has the patient tried and had an inadequate response to at least one conventional therapy option? **ACTION REQUIRED: If Yes, please attach patient's chart notes, medical record documentation, or claims history of previous medications tried, including response to therapy.** If Yes, indicate below and no further questions.
  - Yes - Azathioprine (Azasan, Imuran)
  - Yes - Corticosteroid (e.g., budesonide [Entocort, Uceris], hydrocortisone [Cortifoam, Colocort, Solu-Cortef, Cortef], methylprednisolone [Medrol, Solu-Medrol], prednisone)
  - Yes - Cyclosporine (Sandimmune)
  - Yes - Mesalamine (e.g., Asacol, Lialda, Pentasa, Canasa, Rowasa), balsalazide, olsalazine
  - Yes - Mercaptopurine (Purinethol)
  - Yes - Sulfasalazine
  - Yes - Tacrolimus (Prograf)
  - No
14. Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], corticosteroid [e.g., hydrocortisone [Cortifoam, Colocort, Solu-Cortef, Cortef], methylprednisolone, prednisone, cyclosporine [Sandimmune], mesalamine [Asacol, Lialda, Pentasa, Canasa, Rowasa], balsalazine, olsalazine, mercaptopurine [Purinethol], sulfasalazine, tacrolimus [Prograf])? **ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy.**  Yes  No

Section B: Crohn's Disease

15. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for the treatment of moderately to severely active Crohn's disease? **ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history of previous medications tried.** If Yes, no further questions  Yes  No
16. Does the patient have fistulizing Crohn's disease? **ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting diagnosis.** If Yes, no further questions  Yes  No
17. Has the patient tried and had an inadequate response to at least one conventional therapy option? **ACTION REQUIRED: If Yes, please attach patient's chart notes, medical record documentation, or claims history of previous medications tried, including response to therapy.**

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If Yes, indicate below and no further questions.

- Yes - Sulfasalazine (Azulfidine, Sulfazine)
- Yes - Metronidazole (Flagyl)
- Yes - Ciprofloxacin (Cipro)
- Yes - Prednisone
- Yes - Budesonide (Entocort EC)
- Yes - Azathioprine (Azasan, Imuran)
- Yes - Mercaptopurine (Purinethol)
- Yes - Methotrexate intramuscular (IM) or subcutaneous (SC)
- Yes - Methylprednisolone (Solu-Medrol) (IV)
- Yes - Rifaximin (Xifaxan)
- Yes - Tacrolimus
- No

18. Does the patient have a contraindication or intolerance to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], budesonide [Entocort EC], ciprofloxacin [Cipro], mercaptopurine [Purinethol], methylprednisolone [Solu-Medrol], methotrexate, metronidazole [Flagyl], prednisone, sulfasalazine [Azulfidine, Sulfazine], rifaximin [Xifaxan], tacrolimus)? **ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy.**  Yes  No

Section C: Immune Checkpoint Inhibitor-Related Diarrhea or Colitis

19. Has the patient experienced an inadequate response, intolerance, or contraindication to systemic corticosteroids? **ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy.**  Yes  No

*I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.*

X \_\_\_\_\_

Prescriber or Authorized Signature

Date (mm/dd/yy)

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