Entyvio vial (intravenous)
(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 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
☐ ulcerative colitis
☐ Gastrointestinal toxicity associated with checkpoint inhibitor therapy - Note: Examples of checkpoint inhibitors are Keytruda (pembrolizumab intravenous infusion), Opdivo (nivolumab intravenous infusion), Yervoy (ipilimumab intravenous infusion), Tecentriq (atezolizumab intravenous infusion), Bavencio (avelumab intravenous infusion), Imfinzi (durvalumab intravenous infusion), and Libtayo (cemiplimab-rwlc intravenous infusion).
☐ Graft-versus-host disease
☐ 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) , an etanercept SC product [Enbrel, biosimilar], Entyvio (SC), Ilumya, an infliximab IV product [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]), ustekinumab product [Stelara (IV or SC), biosimilar], 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, Otezla XR, 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.

If Crohn's disease:

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

(if currently receiving) 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

(if currently receiving 6+ months) 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

(if no) Compared with baseline (prior to initiating 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

(if not currently receiving or receiving less than 6 months) Is the requested medication being prescribed by (or in consultation with) a gastroenterologist? ☐ Yes ☐ No

If Ulcerative Colitis:

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

(if currently receiving) 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

(if currently receiving 6+ months) 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

(if no) Compared with baseline (prior to initiating 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

(if not currently receiving or receiving less than 6 months) Is this medication being prescribed by or in consultation with a gastroenterologist? ☐ Yes ☐ No

If Gastrointestinal toxicity associated with checkpoint inhibitor therapy:

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

(if currently receiving) Has the patient already received at least 6 months of therapy with Entyvio intravenous? 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. ☐ Yes ☐ No

(if currently receiving 6+ months) 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 may include clinically significant improvement or normalization of serum markers (for example, C-reactive protein), fecal markers (for example, fecal calprotectin), endoscopic assessment, and/or reduced dosage of corticosteroids. ☐ Yes ☐ No

(if 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

(if initial therapy or currently receiving less than 6 months) According to the prescriber, has the patient developed gastrointestinal toxicity while receiving a checkpoint inhibitor? ☐ Yes ☐ No

(if initial therapy or currently receiving less than 6 months) Is the patient symptomatic despite a trial of at least ONE systemic corticosteroid? - Please note: Examples of a corticosteroid include methylprednisolone and prednisone. ☐ Yes ☐ No

(if initial therapy or currently receiving less than 6 months) Is this medication being prescribed by or in consultation with a gastroenterologist or an oncologist? ☐ Yes ☐ No

If Graft-versus-Host Disease:

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

(if yes) Has the patient already received at least 1 month of therapy with Entyvio intravenous? Please Note: Answer No if the patient has received less than 1 month of therapy or if the patient is restarting therapy with Entyvio intravenous. ☐ Yes ☐ No

(if currently receiving 1+ month[s]) When assessed by at least one objective measure, has the patient experienced a beneficial clinical response from baseline (prior to initiating Entyvio)? Please Note: Examples of objective measures include improvement on endoscopic assessment, normalization of liver function tests, red blood cell count, or platelet count; or resolution of fever or rash. ☐ Yes ☐ No

(if no) Compared with baseline (prior to initiating Entyvio), has the patient experienced an improvement in at least one symptom, such as improvement in oral mucosal or gastrointestinal symptoms (for example, diarrhea, nausea, vomiting, anorexia) or decreased fatigue? ☐ Yes ☐ No

(if not currently receiving or receiving for less than 1 month) Does the patient have acute graft-versus-host disease? ☐ Yes ☐ No

(if not currently receiving or receiving for less than 1 month) Has the patient tried at least one systemic medication for graft-versus-host disease? - Please note: Examples of systemic medications include corticosteroids (for example, methylprednisolone), antithymocyte globulin, cyclosporine, tacrolimus, mycophenolate mofetil, Jakafi (ruxolitinib), Simulect (basiliximab), an etanercept product, an infliximab product, sirolimus, Nipent (pentostatin), and a tocilizumab product. ☐ Yes ☐ No

if not currently receiving or receiving for less than 1 month) Is this medication being prescribed by or in consultation with an oncologist, hematologist, or a physician affiliated with a transplant center? ☐ 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:**_____

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