



**Outpatient Medical Injectable  
Entyvio Authorization Request Form  
Fax to 833-581-1861  
(Medical Benefit Only)**

Member Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Member ID (UMI): \_\_\_\_\_  Medicare  Commercial

Address: \_\_\_\_\_

**ORDERING/ATTENDING PROVIDER**

Physician Name: \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_

Office Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**SITE OF CARE**

**Place of Service (please select one)**

Home Infusion  Office – Professional  Ambulatory Infusion Suite – Professional  Outpatient Hospital

Is the site of care affiliated with a hospital or will the claim be billed as a facility claim?  Yes  No

Place of Service Name: \_\_\_\_\_ NPI: \_\_\_\_\_ Tax ID: \_\_\_\_\_

Address: \_\_\_\_\_

**Drug Supplier (please select one)**

Supplied by a Specialty Pharmacy (for Home Infusion, Office – Professional, or Ambulatory Infusion Suite – Professional)

Pharmacy Name: \_\_\_\_\_ Pharmacy NPI: \_\_\_\_\_

Buy & Bill (for Office – Professional or Outpatient Hospital administration)

**DRUG INFORMATION**

Drug Name: ENTYVIO Strength or Dose: \_\_\_\_\_ Date(s) of service: \_\_\_\_\_

Directions: \_\_\_\_\_ Quantity (# of doses/visits): \_\_\_\_\_

**CLINICAL INFORMATION**

Diagnosis code (ICD10): \_\_\_\_\_ **Diagnosis Description below (please check one)**

|                                               |                                                  |                                        |
|-----------------------------------------------|--------------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Crohn's Disease (CD) | <input type="checkbox"/> Ulcerative Colitis (UC) | <input type="checkbox"/> (Other) _____ |
|-----------------------------------------------|--------------------------------------------------|----------------------------------------|

**\*\*Please verify member's eligibility and benefits through the health plan\*\***

**Please answer all the following clinical questions**

Is the patient's disease moderate to severe?  YES  NO

Did the patient have a tuberculin skin test or Centers for Disease Control (CDC) recommended equivalent to evaluate for latent tuberculosis prior to initiating vedolizumab?  YES  NO

Will the patient be receiving a TNF antagonist (e.g. Humira, Simponi) with Entyvio?  YES  NO

Will the patient be receiving Tysabri along with Entyvio?  YES  NO

Does the patient have any active severe infections including but not limited to: sepsis, tuberculosis, cytomegaloviral colitis, giardiasis, listeria meningitis etc.?  YES  NO

Does the patient have any new or worsening neurological signs or symptoms of John Cunningham virus (JCV) infection or risk of progressive multifocal leukoencephalopathy (PML)?  YES  NO

**New Start**

**Continuation of Therapy**

Date of last infusion: \_\_\_\_\_

Has the member demonstrated disease stability or a beneficial response to therapy?  YES  NO

**Please attach all pertinent clinical information**

**Attached:**  YES  NO

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