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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Entyvio® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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:

Moderately to severely active Crohn's disease

Moderately to severely active ulcerative colitis

Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Select if the patient has had trial and failure, contraindication, or intolerance to the following conventional therapies, as appropriate for the patient's diagnosis:

6-mercaptopurine (Purinethol) Corticosteroids (e.g., prednisone, methylprednisolone)

Azathioprine (Imuran) Methotrexate (Rheumatrex, Trexall)

Aminosalicylates [e.g., mesalamine (Asacol, Pentasa, Rowasa), osalazine (Dipentum), sulfasalazine (Azulfidine, Sulfazine)]

Has the patient had trial and failure, contraindication, or intolerance to one TNF inhibitor [e.g., Humira (adalimumab), Remicade (infliximab)]? **Yes** **No**

Is Entyvio prescribed by or in consultation with a gastroenterologist? **Yes** **No**

Select if Entyvio will be used in combination with the following:

Tysabri (natalizumab)

Tumor necrosis factor (TNF) inhibitor [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Remicade (infliximab)]

Reauthorization:

If this is a reauthorization request, answer the following questions:

Is there documentation the patient has had a positive clinical response to Entyvio therapy? **Yes** **No**

Select if Entyvio will be used in combination with the following:

Tysabri (natalizumab)

Tumor necrosis factor (TNF) inhibitor [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Remicade (infliximab)]

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.
 If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
 For urgent or expedited requests please call 1-800-711-4555.
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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