OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Entvyio® Prior Authorization Request Form

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

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ 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)
❑ Azathioprine (Imuran)
❑ Corticosteroids (e.g., prednisone, methylprednisolone)
❑ 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.