Entyvio

HMSACOM - 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 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** 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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

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

Additional Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*ft* _____*inches*

Indicate where the drug is being dispensed:

❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
❑ Psychiatric Facility ❑ Pharmacy ❑ Other

Indicate where the drug is being administered:

❑ Ambulatory surgical ❑ Home ❑ Inpatient Hospital
❑ Office ❑ Outpatient Hospital ❑ Pharmacy

What is the ICD-10 code? _____

What product is being requested? ❑ Entyvio IV solution ❑ Entyvio SC Pen

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

Criteria Questions:

1. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Xeljanz)?

❒ Yes, *Continue to #2*

❒ No, *Continue to #2*

Indication

2. What is the diagnosis?

❒ Ulcerative colitis, *Continue to #100*

❒ Crohn's disease, *Continue to #200*

❒ Immune checkpoint inhibitor-related diarrhea or colitis, *Continue to #300*

❒ Other, *No Further Questions*

Ulcerative Colitis

100. Has the patient been diagnosed with moderately to severely active ulcerative colitis (UC)?

❒ Yes, *Continue to #101*

❒ No, *Continue to #101*

101. Is the patient an adult (18 years of age or older)?

❒ Yes, *Continue to #102*

❒ No, *Continue to #102*

102. Is the requested drug being prescribed by or in consultation with a gastroenterologist?

❒ Yes, *Continue to #103*

❒ No, *Continue to #103*

103. Which of the following applies to the request for the requested drug?

❒ Initiation of the intravenous (IV) loading dose, *Continue to #104*

❒ Initiation of the intravenous (IV) maintenance dose, *No Further Questions*

❒ Continuation of the intravenous (IV) maintenance dose, *Continue to #105*

❒ Initiation of the subcutaneous (SQ) maintenance dose, *No Further Questions*

❒ Continuation of the subcutaneous (SQ) maintenance dose, *Continue to #105*

104. Which route of administration applies to the prescribed therapy?

❒ Intravenous (vial) loading dose followed by intravenous (vial) maintenance dose, *No Further Questions*

❒ Intravenous (vial) loading dose followed by subcutaneous (syringe or pen) maintenance dose, *No Further Questions*

❒ Intravenous (vial) loading dose only, *No Further Questions*

105. Has the patient achieved or maintained remission OR 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, achieved or maintained remission, *No Further Questions*

❒ Yes, achieved or maintained a positive clinical response, *Continue to #106*

❒ None of the above, *No Further Questions*

106. Which of the following has the patient experienced an improvement in from baseline?

❒ Stool frequency, *No Further Questions*

❒ Rectal bleeding, *No Further Questions*

❒ Urgency of defecation, *No Further Questions*

❒ C-reactive protein (CRP), *No Further Questions*

❒ Fecal calprotectin (FC), *No Further Questions*

❒ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound, *No Further Questions*

❒ Improvement on a disease activity scoring tool (e.g., Ulcerative colitis Endoscopic Index of Severity [UCEIS], Mayo Score), *No Further Questions*

❒ None of the above, *No Further Questions*

Crohn's Disease

200. Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?

❒ Yes, *Continue to #201*

❒ No, *Continue to #201*

201. Is the patient an adult (18 years of age or older)?

❒ Yes, *Continue to #202*

❒ No, *Continue to #202*

202. Is the requested drug being prescribed by or in consultation with a gastroenterologist?

❒ Yes, *Continue to #203*

❒ No. *Continue to #203*

203. Which of the following applies to this request for the requested drug?

❒ Initiation of the intravenous (IV) loading dose, *Continue to #204*

❒ Initiation of the intravenous (IV) maintenance dose, *No Further Questions*

❒ Continuation of the intravenous (IV) maintenance dose, *Continue to #205*

❒ Initiation of the subcutaneous (SQ) maintenance dose, *No Further Questions*

❒ Continuation of the subcutaneous (SQ) maintenance dose, *Continue to #205*

204. Which route of administration applies to the prescribed therapy?

❒ Intravenous (vial) loading dose followed by intravenous (vial) maintenance dose

❒ Intravenous (vial) loading dose followed by subcutaneous (syringe or pen) maintenance dose

❒ Intravenous (vial) loading dose only

Continuation of Therapy

205. Has the patient achieved or maintained remission OR achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?

❒ Yes, achieved or maintained remission, *No Further Questions*

❒ Yes, achieved or maintained a positive clinical response, *Continue to #206*

❒ None of the above, *No Further Questions*

206. Which of the following has the patient experienced an improvement in from baseline?

❒ Abdominal pain or tenderness, *No Further Questions*

❒ Diarrhea, *No Further Questions*

❒ Body weight, *No Further Questions*

❒ Abdominal mass, *No Further Questions*

❒ Hematocrit, *No Further Questions*

❒ Appearance of the mucosa on endoscopy, computed tomography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound, *No Further Questions*

❒ Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score), *No Further Questions*

❒ None of the above, *No Further Questions*

Immune Checkpoint Inhibitor-Related Toxicity

300. Is the requested drug being prescribed by or in consultation with a hematologist or oncologist?

❒ Yes, *Continue to #301*

❒ No, *Continue to #301*

301. Has the patient experienced an inadequate response to systemic corticosteroids or infliximab?

❒ Yes, *Continue to #310*

❒ No, *Continue to #302*

302. Has the patient experienced an intolerance to systemic corticosteroids or infliximab?

❒ Yes, *Continue to #310*

❒ No, *Continue to #303*

303. Does the patient have a contraindication to systemic corticosteroids or infliximab?

❒ Yes, *Continue to #310*

❒ No, *Continue to #310*

Route of Administration

310. What is the prescribed route of administration?

❒ Intravenous (vial), *No Further Questions*

❒ Subcutaneous (syringe or pen), *No Further Questions*

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)**

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512