



## Entyvio

### HMSAMCD - 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.

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**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**

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**Phone: 1-808-254-4414 • Fax: 1-866-237-5512 • www.caremark.com**

**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*

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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*

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- 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)**

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