



**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

This information is issued on behalf of Highmark Blue Shield and its affiliated Blue companies, which are independent licensees of the Blue Cross Blue Shield Association. Highmark Inc. d/b/a Highmark Blue Shield and certain of its affiliated Blue companies serve Blue Shield members in 21 counties in central Pennsylvania and 13 counties in northeastern New York. As a partner in joint operating agreements, Highmark Blue Shield also provides services in conjunction with a separate health plan in southeastern Pennsylvania. Highmark Inc. or certain of its affiliated Blue companies also serve Blue Cross Blue Shield members in 29 counties in western Pennsylvania, 13 counties in northeastern Pennsylvania, the state of West Virginia plus Washington County, Ohio, the state of Delaware, and 8 counties in western New York. All references to Highmark in this document are references to Highmark Inc. d/b/a Highmark Blue Shield and/or to one or more of its affiliated Blue companies.