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)**

☐ Crohn's Disease (CD)	☐ Ulcerative Colitis (UC)	☐ (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**