Entyvio

CareFirst 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 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** 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:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

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

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 CareFirst MR C26742-A, Entyvio 2004-A SGM CFT SOC 5954-A – 06/2025.

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Site of Service Questions (SOS):

A. Where will this drug be administered?
- ❑ Ambulatory surgical, *skip to Clinical Criteria Questions*
- ❑ Home infusion, *skip to Clinical Criteria Questions*
- ❑ Off-campus Outpatient Hospital, *Continue to B*
- ❑ On-campus Outpatient Hospital, *Continue to B*
- ❑ Physician office, *skip to Clinical Criteria Questions*
- ❑ Pharmacy, *skip to Clinical Criteria Questions*

B. Is the patient less than 14 years of age?
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to C*

C. Is this request to continue previously established treatment with the requested medication? ***ACTION REQUIRED: If No, please attach supporting clinical documentation.***
- ❑ Yes - This is a continuation of an existing treatment., *Continue to D*
- ❑ No - This is a new therapy request (patient has not received requested medication in the last 6 months)., *skip to Clinical Criteria Questions*

D. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, or other pre-medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to E*

E. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation.
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to F*

F. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to G*

G. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to H*

H. Are ***all*** alternative infusion sites (pharmacy, physician office, ambulatory care, etc.) **greater than** 30 miles from the patient's home? ***ACTION REQUIRED: If Yes, please attach supporting documentation.***
- ❑ Yes, *Continue to Clinical Criteria Questions*
- ❑ No, *Continue to Clinical Criteria Questions*

Clinical 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*

2. What is the diagnosis?

❒ Ulcerative colitis, *Continue to 3*

❒ Crohn's disease, *Continue to 8*

❒ Immune checkpoint inhibitor-related diarrhea or colitis, *Continue to 13*

❒ Acute graft versus host disease, *Continue to 19*

❒ Other, please specify. _____, *No further questions*

3. Has the patient been diagnosed with moderately to severely active ulcerative colitis (UC)?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. Is the requested drug being prescribed by or in consultation with a gastroenterologist?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

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

❒ Initiation of the intravenous (IV) loading dose, *Continue to 25*

❒ Initiation of the intravenous (IV) maintenance dose, *Continue to 25*

❒ Continuation of the intravenous (IV) maintenance dose, *Continue to 6*

❒ Initiation of the subcutaneous (SQ) maintenance dose, *Continue to 25*

❒ Continuation of the subcutaneous (SQ) maintenance dose, *Continue to 6*

6. Has the patient achieved or maintained remission OR achieved or maintained a 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? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of remission or positive clinical response to therapy.
❒ Yes, achieved or maintained remission ***ACTION REQUIRED****: Submit supporting documentation, Continue to 25*

❒ Yes, achieved or maintained a positive clinical response, *Continue to 7*

❒ None of the above, *No further questions*

7. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response to therapy.

❒ Stool frequency ***ACTION REQUIRED****: Submit supporting documentation, Continue to 25*

❒ Rectal bleeding ***ACTION REQUIRED****: Submit supporting documentation, Continue to 25*

❒ Urgency of defecation ***ACTION REQUIRED****: Submit supporting documentation, Continue to 25*

❒ C-reactive protein (CRP) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 25*

❒ Fecal calprotectin (FC) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 25*
❒ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound ***ACTION REQUIRED****: Submit supporting documentation, Continue to 25*
❒ Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo Score) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 25*

❒ None of the above, *Continue to 25*

8. Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Is the requested drug being prescribed by or in consultation with a gastroenterologist?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

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

❒ Initiation of the intravenous (IV) loading dose, *Continue to 25*

❒ Initiation of the intravenous (IV) maintenance dose, *Continue to 25*

❒ Continuation of the intravenous (IV) maintenance dose, *Continue to 11*

❒ Initiation of the subcutaneous (SQ) maintenance dose, *Continue to 25*

❒ Continuation of the subcutaneous (SQ) maintenance dose, *Continue to 11*

11. Has the patient achieved or maintained remission OR achieved or maintained a 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? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of remission or positive clinical response to therapy.
❒ Yes, achieved or maintained remission ***ACTION REQUIRED****: Submit supporting documentation, Continue to 25*

❒ Yes, achieved or maintained a positive clinical response, *Continue to 12*

❒ None of the above, *No further questions*

12. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response to therapy.

❒ Abdominal pain or tenderness ***ACTION REQUIRED****: Submit supporting documentation, Continue to 25*

❒ Diarrhea ***ACTION REQUIRED****: Submit supporting documentation, Continue to 25*

❒ Body weight ***ACTION REQUIRED****: Submit supporting documentation, Continue to 25*

❒ Abdominal mass ***ACTION REQUIRED****: Submit supporting documentation, Continue to 25*

❒ Hematocrit ***ACTION REQUIRED****: Submit supporting documentation, Continue to 25*
❒ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound ***ACTION REQUIRED****: Submit supporting documentation, Continue to 25*

❒ Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 25*

❒ None of the above, *Continue to 25*

13. Is the requested drug being prescribed by or in consultation with a gastroenterologist, hematologist, or oncologist?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Has the patient experienced an inadequate response to systemic corticosteroids or infliximab? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 17*
❒ No, *Continue to 15*

15. Has the patient experienced an intolerance to systemic corticosteroids or infliximab? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 17*
❒ No, *Continue to 16*

16. Does the patient have a contraindication to systemic corticosteroids or infliximab? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. What is the prescribed route of administration?

❒ Intravenous (vial), *No further questions*

❒ Subcutaneous (syringe or pen), *No further questions*

19. Is the requested drug being prescribed by or in consultation with a hematologist or oncologist?
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

20. Has the patient had an inadequate response to systemic corticosteroids? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 23*
❒ No, *Continue to 21*

21. Does the patient have an intolerance to corticosteroids? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.

❒ Yes, *Continue to 23*
❒ No, *Continue to 22*

22. Does the patient have a contraindication to corticosteroids? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

23. Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?
❒ Yes, *Continue to 24*
❒ No, *Continue to 24*

24. What is the prescribed route of administration?

❒ Intravenous (vial), *No further questions*

❒ Subcutaneous (syringe or pen), *No further questions*

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

❒ Initiation of the intravenous (IV) loading dose, *Continue to 26*

❒ Initiation of the intravenous (IV) maintenance dose, *Continue to 34*

❒ Continuation of the intravenous (IV) maintenance dose, *Continue to 34*

❒ Initiation of the subcutaneous (SQ) maintenance dose, *Continue to 32*

❒ Continuation of the subcutaneous (SQ) maintenance dose, *Continue to 32*

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

❒ Intravenous (vial) loading dose followed by intravenous (vial) maintenance dose, *Continue to 29*

❒ Intravenous (vial) loading dose followed by subcutaneous (syringe or pen) maintenance dose, *Continue to 27*

❒ Intravenous (vial) loading dose only, *Continue to 31*

27. Does the prescribed dose exceed an intravenous loading dose of 300 mg at weeks 0 and 2, and a subcutaneous maintenance dose of 108 mg thereafter starting at week 6?
❒ Yes, *Continue to 28*
❒ No, *Continue to 28*

28. Is the prescribed frequency for the subcutaneous maintenance dose more frequent than one dose every 2 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

29. Does the prescribed dose exceed an intravenous loading dose of 300 mg at weeks 0, 2, and 6, and an intravenous maintenance dose of 300 mg thereafter?
❒ Yes, *Continue to 30*
❒ No, *Continue to 30*

30. Is the prescribed frequency for the intravenous maintenance dose more frequent than one dose every 8 weeks?

❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

31. Does the prescribed dose exceed an intravenous loading dose of 300 mg at weeks 0, 2, and 6?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

32. Does the prescribed subcutaneous maintenance dose exceed 108 mg?
❒ Yes, *Continue to 33*
❒ No, *Continue to 33*

33. Is the prescribed frequency for the subcutaneous maintenance dose more frequent than one dose every 2 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

34. Does the prescribed intravenous dose exceed 300 mg?
❒ Yes, *Continue to 35*
❒ No, *Continue to 35*

35. Is the prescribed frequency for the intravenous maintenance dose more frequent than one dose every 8 weeks?
❒ Yes, *No Further Questions*
❒ No, *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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