BlueCross BlueShield Federal Employee Program

ENTYVIO
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

For claims adjudicated through the pharmacy benefit

For Standard and Basic Option patients Humira including preferred Humira biosimilars, Rinvoq, Skyrizi, Stelara SC, and Tremfya are preferred products. Standard/Basic Option patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

Entyvio (vedolizumab)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Does the patient have a diagnosis of ulcerative colitis (UC) or Crohn's disease (CD)? ***Please select answer below:***

❑**Yes**, Crohn's disease (CD)

a. **Standard/Basic Option Patient**: Would you like to participate in this program and switch the patient to one of the preferred products: Humira including preferred Humira biosimilars, Rinvoq, Skyrizi, Stelara SC, or Tremfya? ❑Yes***** ❑No

****If YES,*** please select one of the following: ❑Humira/preferred biosimilar ❑Rinvoq ❑Skyrizi ❑Stelara (SC) ❑Tremfya

❑**Yes**, ulcerative colitis (UC)

a. **Standard/Basic Option Patient**: Would you like to participate in this program and switch the patient to one of the preferred products: Humira including preferred Humira biosimilars, Rinvoq, Skyrizi, Stelara SC, or Tremfya? ❑Yes***** ❑No

****If YES,*** please select one of the following: ❑Humira/preferred biosimilar ❑Rinvoq ❑Skyrizi ❑Stelara (SC) ❑Tremfya

❑**No**

2. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

a. Is the patient's condition moderate to severely active? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one conventional therapy? ❑Yes ❑No

c. **For claims adjudicated through the pharmacy benefit**: Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a biologic DMARD or targeted synthetic DMARD? ❑Yes ❑No

d. Does the prescriber agree to re-evaluate the patient's condition at week 14 to confirm therapy with Entyvio should be continued? ❑Yes ❑No

e. Does the prescriber agree to initiate dosing via IV infusion on weeks 0 and 2? ❑Yes ❑No

f. After the initial IV infusion, which dosage form will the patient receive? ***Please select answer below:***

❑**Intravenous (IV)**: Does the prescriber agree to administer the medication within the FDA labeled maintenance dose of 300mg intravenously every 8 weeks? ❑Yes ❑No

❑**Subcutaneous (SC) injection**: Does the prescriber agree to administer the medication within the FDA labeled maintenance dose of 108mg subcutaneously every 2 weeks? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

a. Which dosage form will the patient receive? ***Please select answer below:***

❑**Intravenous (IV)**: Does the prescriber agree to administer the medication within the FDA labeled maintenance dose of 300mg intravenously every 8 weeks? ❑Yes ❑No

❑**Subcutaneous (SC) injection**: Does the prescriber agree to administer the medication within the FDA labeled maintenance dose of 108mg subcutaneously every 2 weeks? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

3. Will this medication be given in combination with any other biologic DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify the medication: _____
   DMARDs: Actemra, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
REQUESTS FOR STANDARD AND BASIC OPTION PATIENTS REQUIRES THE BELOW QUESTION TO BE COMPLETED

4. Please select the diagnosis and answer the following questions:

❑Crohn's disease (CD)

a. Does the patient have an intolerance or contraindication* or have they had an inadequate treatment response to TWO of the following preferred medications: Humira including preferred Humira biosimilars, Rinvoq, Skyrizi, Stelara SC, or Tremfya?

Contraindications include (not all inclusive): allergy, autoantibody formation/lupus-like syndrome, or a history of congestive heart failure, hepatitis B virus infection, malignancy, or demyelinating disorder such as multiple sclerosis, Guillain-Barre syndrome, or optic neuritis.

Please select answer: ❑Yes ❑No*

If NO, is there a clinical reason for not trying TWO of the preferred medications? ❑Yes ❑No

❑Ulcerative colitis (UC)

a. Does the patient have an intolerance or contraindication* or have they had an inadequate treatment response to TWO of the following preferred medications: Humira including preferred Humira biosimilars, Rinvoq, Skyrizi, Stelara SC, or Tremfya?

Contraindications include (not all inclusive): allergy, autoantibody formation/lupus-like syndrome, or a history of congestive heart failure, hepatitis B virus infection, malignancy, or demyelinating disorder such as multiple sclerosis, Guillain-Barre syndrome, or optic neuritis.

Please select answer: ❑Yes ❑No*

If NO, is there a clinical reason for not trying TWO of the preferred medications? ❑Yes ❑No