US Family Health Plan
Prior Authorization Request Form for
Vedolizumab (Entyvio) pen

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

· Prior Authorization does not expire. ·

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have moderate to severely active ulcerative colitis?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Humira is the Department of Defense's preferred targeted biologic agent for ulcerative colitis.	☐ Acknowledged Proceed to question **4**	
4. Has the patient had inadequate response to Humira?	☐ Yes Proceed to question **8**	☐ No Proceed to question **5**
5. Has the patient had adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes Proceed to question **8**	☐ No Proceed to question **6**
6. Does the patient have a contraindication to Humira?	☐ Yes Proceed to question **8**	☐ No Proceed to question **7**
7. Has the patient tried and failed or had an inadequate response to IV infliximab?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

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8. Has the patient had an inadequate response to nonbiologic systemic therapy (for example, methotrexate, aminosalicylates (for example, sulfasalazine, mesalamine)), corticosteroids, immunosuppressants (for example, azathioprine), etc?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Has the patient received induction dosing with two intravenous doses of vedolizumab (Entyvio) OR patient has been receiving intravenous vedolizumab (Entyvio) and achieved clinical response or remission beyond week 6?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Will the patient be receiving any other targeted immunomodulatory biologics with vedolizumab including but not limited to the following: certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), infliximab (Remicade), apremilast (Otezla), ustekinumab (Stelara), abatacept (Orencia), anakinra (Kineret), tocilizumab (Actemra), tofacitinib (Xeljanz/Xeljanz XR), rituximab (Rituxan), secukinumab (Cosentyx), ixekizumab (Taltz), brodalumab (Siliq), sarilumab (Kevzara), guselkumab (Tremfya), baricitinib (Olumiant), tildrakizumab (Ilumya), risankizumab (Skyrizi) or upadacitinib (Rinvoq ER)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____