

# 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. Clinical documentation required.

**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?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
2. Does the patient have moderate to severely active ulcerative colitis?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
3. Humira is the Department of Defense's preferred targeted biologic agent for ulcerative colitis.	<input type="checkbox"/> Acknowledged Proceed to question 4	
4. Has the patient had inadequate response to Humira?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No Proceed to question 5
5. Has the patient had adverse reaction to Humira that is not expected to occur with the requested agent?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No Proceed to question 6
6. Does the patient have a contraindication to Humira?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No Proceed to question 7
7. Has the patient tried and failed or had an inadequate response to infliximab (Remicade)?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No <b>STOP</b> Coverage not approved

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<p>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?</p>	<p><input type="checkbox"/> Yes          Proceed to question <b>9</b></p>	<p><input type="checkbox"/> No  <b>STOP</b>          Coverage not approved</p>
<p>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?</p>	<p><input type="checkbox"/> Yes          Proceed to question <b>10</b></p>	<p><input type="checkbox"/> No  <b>STOP</b>          Coverage not approved</p>
<p>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)?</p>	<p><input type="checkbox"/> Yes  <b>STOP</b>          Coverage not approved</p>	<p><input type="checkbox"/> No  <b>Sign and date below</b></p>

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

\_\_\_\_\_

Prescriber Signature

\_\_\_\_\_

Date