OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY/MEDICAL PRIOR AUTHORIZATIO/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-844-723-2094. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

Drug Requested: **Entyvio®** (vedolizumab) **(J3380)**

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Form/Strength: ______________________________

Dosing Schedule: ______________________________ **Length of Therapy:** ______________

Diagnosis: ______________________________ **ICD Code:** ______________

CLINICAL CRITERIA: All applicable boxes below MUST be checked to qualify to ensure the authorization process will NOT be delayed.

- Prescriber is a: ❑ **Rheumatologist** ❑ **Gastroenterologist**

❑ **Diagnosis of:** ❑ **Crohn's Disease** **OR** ❑ **Ulcerative Colitis:**

❑ Patient has tried and failed ***at least one previous 5-Aminosalicylates or Immunomodulators therapy*** ***(check below that applies)***

❑ methotrexate	❑ azathioprine	❑ auranofin
❑ balsalazide	❑ sulfasalazine	❑ leflunomide
❑ mesalamine________	❑ olsalazine	❑ oral aminosalicylates
❑ 6-mercaptopurine		

Medication being provided by (check applicable box(es) below):

❑ **Location/site of drug administration:** ______________________________

NPI or DEA # of administering location: ______________________________

OR

❑ **Specialty Pharmacy:** ❑ **Proprium Rx** **OR** ❑ **Sentara Norfolk General CM Pharmacy**

*****Use of samples to initiate therapy does not meet step edit/preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: ______________________________

Member Optima #: ______________________________ Date of Birth: ______________

Prescriber Name: ______________________________

Prescriber Signature: ______________________________ Date: ______________

Office Contact Name: ______________________________

Phone Number: ______________________________ Fax Number: ______________

Prescriber's DEA OR NPI #: ______________________________

***REVISED/UPDATED: 7/1/2018**