OPTIMA HEALTH PLAN

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) (Medical)**

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

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code**: _____

For Crohn's disease or Ulcerative Colitis: IV – 300 mg at 0, 2, and 6 weeks and then every 8 weeks thereafter. Discontinue therapy in patients who show no evidence of therapeutic benefit by week 14.

Off-label dosing: _____

Please submit literature and progress notes for off-label dosing.

CLINICAL CRITERIA: Check boxes below. All applicable boxes **must** be checked to qualify to ensure authorization will **NOT** be delayed**.**

- **Prescriber is a Gastroenterologis**t

DIAGNOSIS: Check diagnosis that applies.	
❑ **Crohn's Disease**	❑ **Ulcerative Colitis**:

❑ Patient tried and failed **at least one previous 5-Aminosalicylates or Immunomodulators therapy**

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

AND

❑ Trial and failure of budesonide (9mg daily for 8 weeks) or high dose steroids (40-60 mg prednisone)

Medication being provided by (check applicable box below):

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

NPI or DEA # of administering location: _____

OR

❑ **Specialty Pharmacy**: **PropriumRx**

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(Signature page MUST be included with request form.)

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: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 8/21/2014
REVISED/UPDATED: ~~9/26/2014~~; ~~10/31/2014~~; ~~12/30/2014~~; ~~4/3/2015~~; ~~5/23/2015~~; ~~12/30/2015~~; ~~1/4/2016~~; ~~1/29/2016~~; ~~8/19/2016~~; ~~9/22/2016~~; ~~12/28/2016~~; 7/24/2017; ~~9/14/2017~~; ~~9/23/2017~~; ~~12/11/2017~~; ~~4/30/2018~~; **12/13/2018**;