SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/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 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Entyvio® (vedolizumab) **SQ ONLY (Pharmacy Benefit)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

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

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

ATTENTION: Entyvio IV induction (loading dose) for treatment of Crohn's disease or ulcerative colitis can only be billed under the MEDICAL BENEFIT. NDC: 64764-0300-20; J3380

Quantity Limits: 2 pens per 28 days

Adult Dosing:

- Induction IV: NDC: 64764-0300-20 – Entyvio IV 300 mg vial – J3380
  - 300 mg infused intravenously over approximately 30 minutes at Week 0 and Week 2
- Maintenance SubQ: NDC: 64764-0108-20/21 – Entyvio 108 mg/ 0.68 mL prefilled pen
  - Following the first two Entyvio IV doses administered at Week 0 and Week 2 in UC, Entyvio may be
  - switched to subcutaneous (SC) injection at Week 6
  - 108 mg administered by subcutaneous injection starting at Week 6, and then every 2 weeks thereafter
  - Entyvio may be switched from IV infusion to SC injection, for patients in clinical response or remission beyond Week 6. To switch patients to Entyvio SC injection, administer the first SC dose in place of the next scheduled IV infusion and every two weeks thereafter.
  - Discontinue Entyvio in patients who do not show evidence of therapeutic benefit by Week 14

(Continued on next page)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ **Diagnosis: Moderate- to – Severe Crohn's Disease (CD) or Ulcerative Colitis (UC)**
- ❑ **Maintenance Dose- 108 mg administered by subcutaneous injection starting at Week 6, and then every 2 weeks thereafter**

Authorization Criteria: To be reviewed for approval under the pharmacy benefit

- ❑ Member has trial and failure of a compliant regimen of oral corticosteroids (moderate to severe CD or UC) unless contraindicated or intravenous corticosteroids (severe and fulminant CD or UC or failure to respond to oral corticosteroids)
- ❑ Member has a trial and failure of a compliant regimen of azathioprine or mercaptopurine for three (3) consecutive months
- ❑ Member has a trial and failure of a compliant regimen of parenteral methotrexate for at least three (3) consecutive months
- ❑ Member has tried and failed **BOTH** of the preferred therapies below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Pyzchiva® syringe/vial **OR** Starjemza™ (Requires trial and failure of a preferred TNF-alpha inhibitor)

- ❑ **Induction Dose (If required)- One time approval for duration of 1 month, member to receive up to two (2) IV infusion doses**

Authorization Criteria: To be reviewed for one-time approval under the medical benefit

- ❑ Medication will be used as induction therapy
- ❑ Medication being provided by:

  Location/site of drug administration: _____

  NPI or DEA # of administering location: _____
- ❑ Member to receive FDA approved loading dose for 300 mg administered by intravenous infusions over at least 30 minutes at Week 0 and Week 2

Medication being provided by Specialty Pharmacy - PropriumRx

*****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.****

REVISED/UPDATED/REFORMATTED: ~~8/1/2017; 8/26/2017; 12/27/2017; 4/30/2018; 8/18/2018; 10/8/2018; 11/18/2018; 2/4/2019; 5/4/2019; 7/22/2019; 10/16/2019; 10/16/2020; 06/28/21; 8/10/2021; 6/29/2022; 6/20/2023; 5/15/2024; 6/19/2024; 3/25/2025; 12/13/2025; 2/23/2026;~~ **3/11/2026**