

AvMed

MEDICAL 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 1-877-535-1391**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed.**

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. Additional indications may be covered at the discretion of the health plan.

Drug Requested: Entyvio[®] (vedolizumab) IV (J3380) (Medical)

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

Member Name: _____

Member AvMed #: _____ 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 Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

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

- Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

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.

(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.

Prescriber is a Gastroenterologist

DIAGNOSIS: Check diagnosis that applies.

<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Ulcerative Colitis:
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Member tried and failed **at least one previous 5-Aminosalicylates or Immunomodulators therapy below:**

<input type="checkbox"/> Apriso	<input type="checkbox"/> Asacol/HD	<input type="checkbox"/> azathioprine	<input type="checkbox"/> balsalazide
<input type="checkbox"/> Delzicol	<input type="checkbox"/> Lialda	<input type="checkbox"/> mercaptopurine	<input type="checkbox"/> methotrexate
<input type="checkbox"/> olsalazine	<input type="checkbox"/> Pentasa _	<input type="checkbox"/> sulfasalazine	

AND

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

Medication being provided by (check box below that applies):

Location/site of drug administration: _____
NPI or DEA # of administering location: _____

OR

Specialty Pharmacy

For urgent reviews: Practitioner should call AvMed Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****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.****