Mountain Pacific
INNOVATING BETTER HEALTH
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# Montana Healthcare Programs Prior Authorization Request Form for Use of Entyvio® (vedolizumab) SUBQUTANEOUS ADMINISTRATION ONLY

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|---|---|---|
| Member Name: | DOB: | Date: |
| Member ID: | Prescriber Phone: | |
| Prescriber Name/Specialty if applicable: | Prescriber Fax: | |
| Dosage Requested: | | |

**Please complete below information for applicable situation, Initiation or Continuation of therapy:**

**☐ INITIATION OF THERAPY**

1. Member has a diagnosis of moderately to severely active ulcerative colitis: ☐ Yes ☐ No
2. Member is 18 years of age or older: ☐ Yes ☐ No
3. Medication is prescribed by or in consultation with a gastroenterology specialist: ☐ Yes ☐ No

   **Action required**: If not in a specialty clinic or written by a specialist, copy of annual specialty consult with an appropriate specialist is required (please attach copy of consult):

   **Name of specialist:** _____ **Contact date:** _____
4. Member has been approved for initial IV loading dose at Week 0 and Week 2 and will be transitioning to subcutaneous dosing for maintenance therapy: ☐ Yes ☐ No

   **Dates of required loading doses of IV therapy:** Week 0 _____ Week 2 _____
5. Provider attests to **all the following**:

   Member has shown a clinical response to treatment at week 6 and has been evaluated for transition from intravenous to subcutaneous treatment: ☐ Yes ☐ No

   If NO, members who have not shown a response by week 6 may continue to week 14 on intravenous Entyvio®, at which time they will need to demonstrate clinical response for authorization to either transition to subcutaneous or continue intravenous treatment: ☐ Yes ☐ No
6. Provider attests the member will not use Entyvio® concomitantly with other biologics: ☐ Yes ☐ No

**LIMITATIONS:**

Maximum dose for initial authorization: 108mg every 2 weeks subcutaneous **starting at week 6**, followed by 4 additional subcutaneous injections (to week 14).

**Initial authorization will be issued through week 14 (5 doses).**

## ☐ CONTINUATION OF THERAPY

1. Member has documentation of positive clinical response to Entyvio® therapy (e.g., reduction in the frequency and/or severity of symptoms and exacerbations). After initial approval to switch to subcutaneous injection at week 6, member must continue to demonstrate improvement over baseline at week 14: ☐ Yes ☐ No
2. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A - prescriber is specialist.
3. Provider attests the member will not use Entyvio® concomitantly with other biologics: ☐ Yes ☐ No

**LIMITATIONS:**

Maximum dose for renewal authorization: 108mg subcutaneously every 2 weeks

**Reauthorization will be issued for 12 months.**

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**Please complete form, including required attachments, and fax to Drug Prior Authorization Unit at 1-800-294-1350.**

02/2024