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

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 has a diagnosis of moderately to severely active ulcerative colitis: ☐ Yes ☐ No
3. Member is 18 years of age or older: ☐ Yes ☐ No
4. 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:** _____
5. 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 _____
6. 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

     Date of initial IV therapy: _____
   - 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
7. 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.

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

02/2024