



MEDICAL PRECERTIFICATION REQUEST FORM

EOC ID:

Entyvio (vedolizumab) 108

Phone: 1-866-461-7273 Fax back to: 1-888-447-3430

Humana manages the pharmacy drug benefit for your patient. Certain requests for precertification may require additional information from the prescriber. Please provide the following information and fax this form to the number listed above. **Information left blank or illegible may delay the review process.**

Patient name:	Prescriber name:
Member/subscriber number:	Fax: Phone:
Patient date of birth:	Office contact:
Group number:	Tax ID: NPI:
Address:	Address:
City, state, ZIP:	City, state, ZIP:
	Specialty/facility name (if applicable):

If the patient is a Medicare private-fee-for-service patient, which of the following applies?

I am giving notification. Yes____ No____

I am requesting an advanced coverage determination. Yes____ No____

☐ By checking this box, I am requesting multiple drug reviews for this patient.

Expedited/exigent/urgent

☐ By checking this box, I certify an expedited/exigent/urgent review is required. The patient has a health condition that may seriously jeopardize his/her life or ability to regain maximum function. **(Please include explanation of exigency in the space below.)**

Drug name and strength:	Dose per infusion/injection:
Directions/SIG:	Number of infusions/injections:
Quantity/units:	Number of cycles/frequency:

Is this a request for services already provided? Yes ____ No ____

If yes, please provide date of service: __/__/__

(Note: All reviews will be processed with generic equivalents for brand drugs whenever possible.)

Please attach pertinent medical history or information for this patient that may support approval and sign this form.

Q1. Please provide diagnosis: *
Q2. Please provide J-Code, if applicable:
Q3. Please provide ICD Diagnostic Codes:
Q4. Please indicate where the drug is being dispensed: * <input type="checkbox"/> Pharmacy dispensed to patient <input type="checkbox"/> Pharmacy shipped to prescriber



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- ☐ Prescriber dispensed
☐ Other

Q5. If other, please specify:

Q6. Is the drug requested part of a clinical trial?

- ☐ Yes ☐ No

Q7. If yes, please provide the registration or identification number for the specific trial for which this drug is being studied (e.g. ClinicalTrials.gov Identifier: NCT12345678): _____ *

Q8. Please indicate if this request is a: *

- ☐ New start/initial request ☐ Continuation/reauthorization request

Q9. Is the patient 18 years of age or older? *

- ☐ Yes ☐ No

Q10. Does the patient have a diagnosis of moderately to severely active ulcerative colitis? *

- ☐ Yes ☐ No

Q11. Does the patient have a diagnosis of moderately to severely active Crohn's disease? *

- ☐ Yes ☐ No

Q12. Has the patient had prior therapy, contraindication, or intolerance with any of the following: (Please mark all that apply) *

- ☐ Aminosalicylates (e.g. mesalamine and sulfasalazine)
☐ Corticosteroids (e.g. prednisone, hydrocortisone, methylprednisolone)
☐ Immunomodulators (e.g. azathioprine)
☐ None of the above

Q13. Additional comments:

Prescriber signature

Date

I declare under penalty of perjury under the laws of the United States of America that the information provided is true and correct. This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document. LC3035ALL1019 2020-1-1



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