BlueCross BlueShield Federal Employee Program

Send completed form to:
Blue Shield of California
Fax: 1-855-895-3504

ENTYVIO
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form. All incomplete and illegible forms will be returned to the patient.

CARDHOLDER COMPLETES

Date: ____/ _____/ _____

Cardholder Name: _____/ _____/ _____
First MI Last

Patient Name: _____/ _____/ _____
First MI Last

Patient Address: _____
Street City State Zip

Patient Date of Birth: ____/ _____/ _____ Sex: M ____ F _____ **R** | | | | | | | | | |
Cardholder Identification Number

PHYSICIAN COMPLETES

Humira is the preferred/participating product. Please consider prescribing a preferred/participating product. Patients who switch to Humira will be eligible for 2 copays at no cost in the 2016 benefit year.

Would you like to switch to Humira? ❑Yes, switch to Humira ❑No, continue with Entyvio

NOTE: Form must be completed in its **entirety** for processing

1. What is the patient's **diagnosis?**
   - ❑ **Ulcerative Colitis (UC)**
   - ❑ **Crohn's Disease (CD)**
   - ❑ **Other diagnosis** ***(please specify):*** _____

INITIATION of Therapy – Complete SECTION A	**CONTINUATION of Therapy – Complete SECTION B**

SECTION A: INITIATION of therapy ***(please answer the following questions)***

1. Is the patient's condition moderate to severely active? ❑Yes ❑No
2. Has the patient experienced an inadequate response, intolerance or loss of effectiveness with a tumor necrosis factor (TNF) block such as: Enbrel, Humira, Remicade, or Simponi? ❑Yes ❑No
3. Will the patient use Entyvio concurrently with a TNF blocker such as: Enbrel, Humira, Remicade, Cimzia or Simponi? ❑Yes ❑No
4. Will the patient use Entyvio concurrently with interleukin antagonists anakinra (Kineret) or natalizumab (Tysabri)? ❑Yes ❑No
5. Has the patient experienced an inadequate response, intolerance or loss of effectiveness with an immunomodulator such as azathioprine, cyclosporine, methotrexate, mercaptopurine, tacrolimus? ❑Yes ❑No
6. Has the patient experienced an inadequate response, loss of effectiveness or demonstrated dependence on corticosteroids? ❑Yes ❑No

SECTION B: CONTINUATION of therapy ***(please answer the following question)***

1. Has the patient undergone re-evaluation to show improvement or stabilization in their condition? ❑Yes ❑No

REQUESTS FOR ENTYVIO REQUIRE PAGE 2 TO BE COMPLETED FOR PROCESSING

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.

_____ (_____) _____ (_____) _____
Physician Name (Print Clearly) Phone Fax

_____ _____ _____ _____
Street Address City State Zip

_____ _____ _____/ _____ / _____
Prescriber's NPI Physician Signature Date

BlueCross BlueShield
Federal Employee Program

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Fax: 1-855-895-3504

Attn. Clinical Services
Fax: **1-877-378-4727**

PHYSICIAN COMPLETES

REQUESTS FOR ENTYVIO REQUIRE PAGE 2 TO BE COMPLETED FOR PROCESSING

Patient Name: _____ **DOB:** _____ **Cardholder ID:** _____

1. **Has the patient received at least 30 days of Entyvio within the past 4 months? ❑Yes ❑No**
2. **If the patient has previously been treated with Entyvio, have they had a break for more than 4 months due to a medical reason such as pregnancy, surgery, or intercurrent medical illness? ❑Yes* ❑No**
   ***If YES*, please specify medical reason:**

   _____

   _____
3. **Does the patient have a contraindication to Humira? ❑Yes* ❑No**
   ***If YES*, please provide specific details regarding contraindication below:**

   _____

   _____
4. **Does the patient have a history of demyelinating disorder? ❑Yes ❑No**
5. **Does the patient have a history of congestive heart failure? ❑Yes ❑No**
6. **Does the patient have a history of Hepatitis B Virus infection? ❑Yes ❑No**
7. **Does the patient have autoantibody formation / lupus-like syndrome? ❑Yes ❑No**
8. **Has the patient had an inadequate response, intolerance, or confirmed adverse event to Humira? ❑Yes* ❑No**
   ***If YES*, please describe the inadequate response, intolerance, or adverse event below:**

   _____

   _____
9. **Has the patient tried Humira? ❑Yes ❑No**
10. **Is there a clinical reason for not trying Humira? ❑Yes* ❑No**
    ***If YES*, please describe the clinical reason below:**

    _____

    _____