TRICARE Prior Authorization Request Form for
vedolizumab **(Entyvio pen)**

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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior Authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have moderate to severely active ulcerative colitis?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Humira is the Department of Defense's preferred targeted biologic agent for ulcerative colitis.	☐ Acknowledged Proceed to question **4**	
4. Has the patient had inadequate response to Humira?	☐ Yes Proceed to question **8**	☐ No Proceed to question **5**
5. Has the patient had adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes Proceed to question **8**	☐ No Proceed to question **6**
6. Does the patient have a contraindication to Humira?	☐ Yes Proceed to question **8**	☐ No Proceed to question **7**
7. Has the patient tried and failed or had an inadequate response to infliximab (Remicade)?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

8. Has the patient had an inadequate response to nonbiologic systemic therapy (for example, methotrexate, aminosalicylates (for example, sulfasalazine, mesalamine)), corticosteroids, immunosuppressants (for example, azathioprine), etc?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Has the patient received induction dosing with two intravenous doses of vedolizumab (Entyvio) OR patient has been receiving intravenous vedolizumab (Entyvio) and achieved clinical response or remission beyond week 6?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Will the patient be receiving any other targeted immunomodulatory biologics with vedolizumab including but not limited to the following: certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), infliximab (Remicade), apremilast (Otezla), ustekinumab (Stelara), abatacept (Orencia), anakinra (Kineret), tocilizumab (Actemra), tofacitinib (Xeljanz/Xeljanz XR), rituximab (Rituxan), secukinumab (Cosentyx), ixekizumab (Taltz), brodalumab (Siliq), sarilumab (Kevzara), guselkumab (Tremfya), baricitinib (Olumiant), tildrakizumab (Ilumya), risankizumab (Skyrizi) or upadacitinib (Rinvoq ER)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[21 November 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: