

# Clinical Criteria Worksheet: Vedolizumab (Entyvio®)

## Claim Submission

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- Claim processing may be delayed if the information submitted in this worksheet is illegible.
- If the worksheet is left blank or information is missing the claim will be rejected for not enough documentation and reimbursement will be delayed.
- A claim should not be submitted until the drug has been administered to the patient.
- The manufacturer invoice showing the acquisition cost of the drug administered, including all discounts, rebates, and incentives must be submitted with the claim. The invoice must be dated within 6 months prior to the date of service and/or should include the expiration date of the drug, or it will be rejected for not enough documentation.

## Enrollee Information

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Enrollee Last Name:

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Enrollee First Name:

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Date of Birth (MM/DD/YYYY):

		/			/					
--	--	---	--	--	---	--	--	--	--	--

Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter):

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Address:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

City, Town or Post Office:

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State:

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ZIP Code:

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## Prescriber Information

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Prescriber Last Name:

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Prescriber First Name:

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National Provider Identifier (NPI) Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Preferred Contact (Telephone Number)

			-				-						
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Enrollee Last Name:

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Enrollee First Name:

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### Clinical Criteria – Drug Information

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**Drug Administration:**

Provide the date of drug administration (MM/DD/YYYY):

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Provide the expiration date of the drug if the invoice date is greater than 6 months from the date of drug administration (MM/DD/YYYY):

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**Drug Name and Strength:**

vedolizumab (Entyvio®) 300 mg vial

**Quantity:** \_\_\_\_\_

**Directions:** \_\_\_\_\_

**New Treatment:**     Yes     No

If **No**, date therapy initiated: \_\_\_\_\_

### Clinical Criteria – Diagnosis

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1. Diagnosis related to use (please select one diagnosis):

Food and Drug Administration Approved Indications:

- Moderately to severely active Crohn’s disease
- Moderately to severely active ulcerative colitis
- Other: \_\_\_\_\_

2. Was the patient’s medication record reviewed to confirm that the patient is not utilizing vedolizumab with other biological products to treat the same condition?

Yes     No

**Enrollee Last Name:**

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**Enrollee First Name:**

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## Clinical Criteria

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3. Please indicate if this request is for the initiation or continuation of vedolizumab therapy?

Initiation     Continuation

4. Prior to initiation of vedolizumab therapy, has the patient had a trial of a disease-modifying antirheumatic drug (DMARD) OR a tumor necrosis factor inhibitor (TNFi)?

Yes     No

## Attestation

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*I attest that this drug is medically necessary for this patient and that all of the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by the New York State Medicaid Program.*

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**Prescriber Signature (Required)**

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**Date (MM/DD/YYYY)**