Clinical Criteria Worksheet:
Vedolizumab (Entyvio®)

Claim Submission

- 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

Enrollee Last Name:

Enrollee First Name:

Date of Birth (MM/DD/YYYY):

/ /

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

Address:

City, Town or Post Office:

State:

ZIP Code:

Prescriber Information

Prescriber Last Name:

Prescriber First Name:

National Provider Identifier (NPI) Number:

Preferred Contact (Telephone Number)

– –

Enrollee Last Name: | | | | | | | | | | | | |

Enrollee First Name: | | | | | | | | | | | | |

Clinical Criteria – Drug Information

Drug Administration:

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

		/			/				

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):

		/			/				

Drug Name and Strength:

☐ vedolizumab (Entyvio®) 300 mg vial

Quantity: _____

Directions: _____

New Treatment: ☐ Yes ☐ No

If **No**, date therapy initiated: _____

Clinical Criteria – Diagnosis

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:

Enrollee First Name:

Clinical Criteria

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

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.

Prescriber Signature (Required) **Date (MM/DD/YYYY)**