Clinical Criteria Worksheet:
Vedolizumab (Entyvio®)

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): _____

Clinical Criteria – Drug Information

Drug Administration:

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

Drug Name and Strength:

☐ vedolizumab (Entyvio®) 300 mg vial

New Treatment: ☐ Yes ☐ No

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

Enrollee Last Name: **Enrollee First Name:**

_____ _____

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

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 conventional agent, 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)**