Medical drug benefit
Prior authorization request

WellSense HEALTH PLAN

Entyvio or Ilumya

Version20 Effective: 06/26/2023

Phone: 877-417-1839 (NH Medicaid)
Fax: 866-539-7185

* Some plans might not accept this form for Medicare or Medicaid requests

This form is being used for:	
Check if Expedited Review/Urgent Request:	☐ (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)

1. Patient information	
Patient Name:	DOB:
Member ID #:	

2. Prescriber information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA/xDEA:
Prescriber Point of Contact Name (POC) (if different than provider):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
Prescribing Clinician or Authorized Representative Signature:	Date:

3. Drug request	
Please select the drug you are requesting (select **one**):	
☐ Entyvio	☐ Ilumya

4. Requested dosing

Please document the requested dosing:

5. Concurrent use

Will the member be using the requested medication concurrently with a biologic or a targeted synthetic DMARD?

☐ Yes

☐ No

6. Diagnosis

What is the diagnosis the requested medication is being used to treat: (select **one**)

☐ Crohn's disease (proceed to Q7)

☐ Ulcerative Colitis (proceed to Q8)

☐ Plaque psoriasis (proceed to Q9)

☐ Other, please indicate diagnosis below and include supporting clinical documentation for use in this indication and attached applicable chart notes in faxed request.

7. Crohn's disease

If the selected diagnosis is Crohn's disease, please select **all** that apply:

☐ Member has tried or is currently taking systemic corticosteroids, or corticosteroids are contraindicated

☐ Member has tried one conventional systemic therapy (e.g. azathioprine, 6-mercaptopurine, or methotrexate)

☐ Member has enterocutaneous (perianal or abdominal) or rectovaginal fistulas

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☐ Member has ileocolonic resection

☐ Other (please specify):

8. Ulcerative colitis

If the selected diagnosis is Ulcerative Colitis, please select **all** that apply

☐ Member has tried one systemic therapy (e.g. 6-mecaptopurine, azathioprine, cyclosporine, tacrolimus, or a corticosteroid)

☐ Other (please specify)

9. Plaque psoriasis

If the selected diagnosis is Plaque psoriasis, please select **all** that apply:

☐ Member has tried at least one traditional systemic agent for at least 3 months, or has an intolerance (e.g. methotrexate, cyclosporine, acitretin tablets, or psoralen plus ultraviolet A light (PUVA)

☐ Member has a contraindication to methotrexate

☐ Other clinical documentation (please specify):

10. Specialty of the prescriber

Please indicate what specialty the prescriber is (select any that apply):

☐ Dermatologist

☐ Gastroenterologist

☐ Other (please indicate what specialty below):

11. Initial or continuing therapy

Is the request for initial or continuing therapy?

☐ Initial (Proceed to Q16)

☐ Continuation (Proceed to Q12)

12. Diagnosis

Please select the appropriate diagnosis

☐ Crohn's disease (Proceed to Q13)

☐ Ulcerative colitis (Proceed to Q13)

☐ Plaque psoriasis (Proceed to Q14)

13. Crohn's disease and ulcerative colitis

Has the member had a response to therapy? (Proceed to Q15)

☐ Yes ☐ No

14. Plaque psoriasis

Please choose **all** of the following that apply (Proceed to Q15):

☐ Member has been established on the requested drug for at least 90 days

☐ Member experienced a beneficial clinical response from baseline in estimated body surface area, erythema, induration/thickness, and/or scale of areas affected by psoriasis

☐ Member experience an improvement in at least one system compared to baseline

☐ Other (please specify):

15. Member's response to therapy

Please choose all of the following that apply:

☐ Decreased stool frequency	☐ Decreased pain
☐ Decreased rectal bleeding	☐ Decreased itching or burning

☐ Other (please indicate below):

22. HCPCS Codes

Please document the applicable HCPCS codes (e.g. J codes or Q codes) being requested, including the number of units and number of visits (using the space below):

☐ HCPCS / Qcodes:

☐ Number of units:

☐ Number of visits:

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.

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