EPSRX

ENTYVIO REFERRAL FORM

CALL: 844-800-5377
FAX: 800-239-0363
www.evolutionaryrx.com

Patient Name: _____
Home Address _____ City _____ State _____ Zip _____
Home Phone: _____ Cell/Work Phone: _____ Birth Date: _____ / _____ / _____
Email: _____ Okay to call patient: ☐ Yes ☐ No
Primary Insurance (PI) Name: _____ PI Phone: _____
Commercial ☐ Medicare/Medicaid ☐ Pending Medicaid ☐ No Insurance PI Subscriber ID: _____
PI Subscriber Name: _____ PI Subscriber Birth Date: _____ / _____ / _____ Policy/Group ID #: _____
Secondary Insurance (PI) Name: _____ SI Phone: _____
Commercial ☐ Medicare/Medicaid ☐ Pending Medicaid ☐ No Insurance SI Subscriber ID: _____

HEALTHCARE PROVIDER INFORMATION

Healthcare Provider Name: _____ Clinic Name (if applicable): _____
Address _____ City _____ State _____ Zip _____
Contact Name: _____ Phone: _____ Fax: _____
Do you prefer to be the sole point of contact? ☐ Yes ☐ No DEA#: _____ Tax ID #: _____ Fax: _____
NPI #: _____ (for additional summary of benefits)
SITE OF ADMINISTRATION ☐ Same as above
(If fax number is provided, a copy of patient's summary of benefits will be sent to the site of administration)
Facility Name: _____ Contact Name: _____
Address _____ City _____ State _____ Zip _____
Phone: _____ Fax: _____ Site Tax ID#: _____ Site NPI #: _____

TREATMENT INFORMATION

Patient Diagnosis: (Checkmark ICD-10 Code)

Ulcerative Colitis

☐ K51.00 Ulcerative (chronic) pancolitis without complications
☐ K51.20 Ulcerative (chronic) proctitis without complications
☐ K51.30 Ulcerative (chronic) rectosigmoiditis without complications
☐ K51.50 Left-sided colitis without complications
☐ K51.80 Other ulcerative colitis without complications
☐ K51.90 Ulcerative colitis, unspecified, without complications

Crohn's Disease

☐ K50.00 Crohn's disease of small intestine without complications
☐ K50.10 Crohn's disease of large intestine without complications
☐ K50.80 Crohn's disease of both small and large intestine without complications
☐ K50.90 Crohn's disease, unspecified, without complications

Has patient started therapy? ☐ Yes ☐ No If yes, last treatment date: _____ / _____ / _____
Prior biologic therapy? ☐ Yes ☐ No Please list most recent therapy and date/duration: _____
_____

PRESCRIPTION (REQUIRED FOR SPECIALTY PHARMACY BENEFIT)

Initiation: Entyvio 300 mg IV
Dispense:
☐ Qty: _____ vial(s) Refill _____ times
Dosage and Directions for Use:
☐ 300 mg IV infusion at Week(s) _____
☐ Other _____

Continuing: Entyvio 300 mg IV
Dispense:
☐ Qty: _____ vial(s) Refill _____ times
Dosage and Directions for Use:
☐ 300 mg IV infusion at Week(s) _____
☐ Other _____

Do you intend to buy & bill? ☐ Yes ☐ No

If no, please provide preferred speality pharmacy _____ and phone number (if any): _____

PRESCRIPTION AUTHORIZATION/CERTIFICATION OF MEDICAL NECESSITY/AUTHORIZATION TO RELEASE PATIENT INFORMATION

By signing this form, you are certifying that a) you authorize Takeda Pharmaceuticals America, Inc. and it's agents or contractors to forward the above statement of medical necessity and furnish any information on this form to the insurer of the above-named patient and b) the described therapy above is medically necessary and c) you have received from the patient identified above, or his/her personal representative, the necessary authorization to release, in accordance with applicable federal and state privacy laws and regulations, referenced medical and/or other patient information relating to the need for Entyvio therapy to Takeda Pharmaceuticals America, Inc. and its agents or contractors for the purpose of seeking information related to coverage for Entyvio therapy and/or assisting in initiating or continuing Entyvio therapy.

Prescriber Signature: _____ **Date** _____/_____/_____

PLEASE FAX THE SIGNED FORM TO (805) 456 - 0416. FOR QUESTIONS, PLEASE CALL ENTYVIO CONNECT AT 1-855-ENTYVIO (1-855-368-9846), MONDAY TO FRIDAY, FROM 8AM TO 8PM EST (EXCEPT HOLIDAYS)

Please See Second Page

PATIENT AUTHORIZATION AND CO-PAY CONSENT FORM FOR ENTYVIO CONNECT

Entyvio Connect can provide certain support to you and on your behalf during the search for Entyvio therapy reimbursement and support programs including co-pay assistance. The Entyvio Connect program is an agent of Takeda Pharmaceuticals America, Inc. In order to provide this support, Entyvio Connect will need to use your health information (called "Protected Health Information" or "PHI"), and to share it with your health plan and the pharmacy that will receive your doctor's prescription. This authorization will allow your healthcare providers, health plans, and health insurers that maintain PHI about you to disclose your PHI to Entyvio Connect so that Entyvio Connect may provide this support to you or on your behalf.

PATIENT AUTHORIZATION AND RELEASE TO COLLECT, USE, AND DISCLOSE MEDICAL INFORMATION

By signing this Authorization, I authorize my physician, health plans and pharmacy providers to disclose my Protected Health Information, including, but not limited to, information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form and any prescription, to Entyvio Connect and its representatives, agents, and contractors for the following purposes: (1) to assist me in my health plan coverage for Entyvio, as well as determine my eligibility for co-pay assistance; (2) to communicate with my healthcare providers and me about my medical care; (3) to facilitate the provision of products, supplies or services by a third party including, but not limited to specialty pharmacies; and (4) to register me in any applicable product registration program required for my treatment.

By checking the box below, I also authorize Takeda Pharmaceuticals America, Inc., its affiliates, and business partners to use my personal information to provide me with information and offers related to Entyvio, the diseases and conditions it treats, and related treatment options.

I consent to receive product and disease-state information from Takeda Pharmaceuticals America, Inc., its affiliates, service providers, and co-promotion partners. I consent to be contacted through the following means (Please check the boxes that apply and fill in your information. You can check more than one box.):

☐ Email: _____ ☐ Postal Mail, at the address below.

I understand that my PHI disclosed under this Authorization may no longer be protected by federal privacy law and may be re-disclosed by Entyvio Connect. I understand that I may refuse to sign this Authorization and that my treatment, payment, enrollment or eligibility for benefits is not conditioned on my signing this Authorization. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to Entyvio Connect, PO Box 29219, Phoenix, AZ 85038-9219, but that this cancellation will not apply to any information already used or disclosed through this Authorization. This Authorization will expire within five (5) years from today's date, unless a shorter period is provided for by state law.

Signature: _____ **Date** _____/_____/_____

Address: _____

Patient's Printed Name: _____ **Phone:** _____ ☐ **OK to leave a message at this number.**

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