Understanding Your Patient's Benefit Verification Form

After *EntyvioConnect* verifies a patient's insurance coverage, your office will receive a summary of the findings, like the one below. We have added descriptions to each section of the form so you understand the benefit findings. A completed sample form is also included on the last page as a reference.

	EntyvioCor Insurance Benefit Ver		A	Requesting Information
Phone	e: 1-855 –ENTYVIO (368-98	46) Fax: 1- 877-488-6		Key patient and office information received during
Disclaimer: EntyvioConnec third-party payer. This is no liability for payment of any information concerning the	t is an information service only. The informat of a guarantee of coverage or reimbursemer claims, benefits, or costs. Confidentiality N named addressee. If you are not the named his information is PROHIBITED. If you recei	on contained below has been provi it now or in the future, and the Ent otice: This message may contain C addressee or his/her authorized re	nnect disclaims ENTIAL tative, your	EntyvioConnect enrollment.
REQUESTING INFORMA				
Requestor:	Physician:	SR ID#:		
acility:	Office Phone:	Office Fax:	B	
Patient:	Patient DOB:	Date Sent/Agent:		Insurance Information
NSURANCE INFORMAT	ION			
Payer: Primary/Secondar	y:	Plan Type:	_	Health plan contacted by <i>EntyvioConnect</i> to
Phone:	Policy ID: Plan Renew	al Date: Call Ref	#:	complete benefits investigation.
BENEFIT INVESTIGATIO				
Access Options	Entyvio HCPCS	Entyvio NDC		
Benefit Type	Major Medical Prescriptio J3380 64764-300			
Drug Code				
Covered Administration	CPT 96365 / 96413	See Medical Ben	C	
Setting of Care				Benefit Investigation Results
Vetwork Status				benefit investigation Results
Coverage				EntyvioConnect typically only reviews information
Coverage Reason				5 51 5 5
Co-pay / Coinsurance				related to the medical benefit (HCPCS column).
Deductible				If there is no medical benefit available under the
Dut-of-Pocket Maximum				patient's health plan, or if the provider does not
Annual Maximum				
imitations/Restrictions				intend to buy and bill, EntyvioConnect will review
	OPTIONS - Mandated Option			information for the pharmacy benefit
Major Medical 🗌 Prescripti	_	Phone Number:		(NDC column).
PRIOR AUTHORIZATION	I _ / PRE-DETERMINATION _			
Submission Method:		Estimated Turnaround Time		EntyvioConnect will include information on:
Payer Phone Number:		Payer Fax Number:		
Required Information:				• Setting of Care and Network Status: Site of care
F PRIOR AUTHORIZATI	ON IS ON FILE:			-
Approval Number:	Approval Dates:	Approve	:	that is covered for Entyvio administration
ADDITIONAL INFORMAT	FION			Coverage and Coverage Beacons Delevent states
				 Coverage and Coverage Reason: Relevant detai

- Out-of-Pocket costs: Includes **Co-pay/ Coinsurance, Deductible, Out-of-Pocket Maximum**, and **Annual Maximum**
- Limitations/Restrictions: Additional details that may affect patient cost and coverage

HCPCS=Healthcare Common Procedure Coding System; NDC=National Drug Code.





Understanding Your Patient's Benefit Verification Form (cont'd)

Phon	e: 1-855 –	ENTYVIC) (368-9846)	Fax	c: 1- 87	7-488-68	314	
Disclaimer: EntyvioConne third-party payer. This is r liability for payment of an information concerning th DISCLOSURE or USE then destroy this documen	ct is an informat lot a guarantee y claims, benefi e named addres this information	ion service only of coverage or ts, or costs. Co see. If you are	r. The information c reimbursement no onfidentiality Notice not the named add	ontained w or in t This m ressee of	d below has the future, a nessage may or his/her au	been provide and the Entyw contain COI ithorized repr	d by the i ioConneo NFIDENT esentative	ct disclai 'IAL e, your
REQUESTING INFORM								
Requestor:		Physician:		5	SR ID#:	R ID#:		
acility:		Office Phone	ə:		Office Fax:			
Patient:		Patient DOB	C .	[Date Sent/A	gent:		
NSURANCE INFORMA	TION							
Payer: Primary/Seconda	ry:		_	Plan T	ype:			
Phone:	Policy ID:		Plan Renewal Da	ate:		Call Refere	ence #:	
BENEFIT INVESTIGATI	ON RESULTS							
Access Options	Entyvio HCP					io NDC		
Benefit Type	Major Medica				Presc			
Drug Code	J3380				64764	64764-300-20		
Covered Administration	CPT 96365	CPT 96365 🗌 / 96413 🗌				See Medical Benefit		
Setting of Care								
Vetwork Status								
Coverage								
Coverage Reason								
Co-pay / Coinsurance								
Deductible								
Out-of-Pocket Maximum								
Annual Maximum								
imitations/Restrictions								
SPECIALTY PHARMAC	Y OPTIONS -	Mandated	Optional					
Major Medical 🗌 Prescrip	tion 🗌				Phone Nu	mber:		
RIOR AUTHORIZATIO	N 🗌 / PRE-D	ETERMINATI	ON 🗌					
Submission Method:			E			Estimated Turnaround Time:		
Payer Phone Number:		Payer			yer Fax Number:			
Required Information:				•				
F PRIOR AUTHORIZAT	ION IS ON FIL	E:						
Approval Number:		Approval Dates:		Approved Units:				

Specialty Pharmacy Options

D

Indicates if a health plan requires a specialty pharmacy (SP) to be used to obtain Entyvio (vedolizumab) ("Mandated" will be checked). If "Optional" is selected, you can obtain Entyvio from an SP or SP distributor. If neither is selected, then you must obtain Entyvio from a specialty distributor.

Prior Authorization/Pre-Determination

Provides details on whether a prior authorization (PA) or pre-determination is required and how to submit information to the health plan.

If Prior Authorization is on File

Provides details on an approved PA on file and the associated approval information for your reference.

Additional Information

Summarizes key points from all of the sections contained in this document. Typical information will include how to find a PA form, how to check the policy for additional information, whether the patient is registered in the Co-Pay Program, and the associated Co-Pay Program member ID.

Example of Completed Benefit Verification Form

EntyvioConnect

Insurance Benefit Verification Form

SAMPLE ONLY

Phone: 1-855 - ENTYVIO (368-9846) Fax: 1-877-488-6814

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REQUESTIN	IG INFORMA	TION		1						
Requestor:	John Doe		Physician:			SR ID#:		0123456789		
Facility:	Main Street	GI Clinic	Office Phone:	(123) 555-5555		Office Fax:		(123) 444-4444		
Patient:	Jack Jones NCE INFORMATION		Patient DOB:	01-02-1977		Date Sent/Agent:		06-02-2021		
Payer: Primary/Secondary: Health						Plan Type: Commercial				
Phone: (888) 123-4567 Policy ID: H			00123	Plan Renewal D	ate: 0	1-01-2022	Call Refer	ence #: 00001		
	VESTIGATIO									
Access Optio	ons	Entyvio HCPCS					Entyvio NDC			
Benefit Type		Major Medical					Prescription			
Drug Code		J3380					64764-300-20			
Covered Administration		CPT 96365 🔀 / 96413 🔀					See Medical Benefit			
Setting of Car		Physician offic	e							
Network Status		In network								
Coverage		Covered					Coverage through Major Medical			
Coverage Reason		Per insurer guidelines								
Co-pay / Coinsurance		25%								
			,000; \$1,500 met							
Out-of-Pocket		\$5,000; \$1,50	0 met							
Annual Maxim	num	N/A								
Limitations/Re			dical necessity							
SPECIALTY	PHARMACY	OPTIONS -	Mandated	Optional	Х					
Major Medical 🔀 Prescription 🗌						Phone Number				
PRIOR AUT	HORIZATION	I 🗌 / PRE-DE	ETERMINATIO	N 🗌						
Submission M	lethod:	Fax			Estim	ated Turnarc	ound Time:	Up to 48 hours		
Payer Phone	hone Number: (888) 123-4		567		Paye	Payer Fax Number:		(888) 999-9999		
Required Info				pies	+ · ·					
IF PRIOR A	JTHORIZATI	ON IS ON FILI								
Approval Number:		Approval Dates:			Units:					
ADDITIONA	L INFORMAT	ΓΙΟΝ						•		
		nat can be retrie s 12345678910	ved at www.hea	althplanABC/PA.	Patient	is eligible for	. co-pay sub	oport and has		

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