Understanding Your Patient's Benefit Verification Form

After *EntyvioConnect* verifies a patient's insurance coverage for either IV administration and maintenance or SC pen maintenance, your office will receive a summary of the findings. The first sample form is blank, with explanations next to each section. The second sample shows what it might look like completed when it comes back to you for review.

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

Insurance Benefit Investigation Results for Patients

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A PATIENT INFORMATION

Patient Name: [Firstname Lastname]	Patient DOB: [MM/DD/YYYY]	SR ID#: [SR#]
Insurance: [Payer Name]	Plan Type: [plan type]	
Policy ID: [Payer Policy#]	Plan Renewal Date: [Renewal Date]	

B PHYSICIAN INFORMATION

Physician: Dr. [Provider Name]	Phone: [HCP Phone]	Fax: [HCP Fax]
Facility: [Facility Name]	Network Status: [In-network/Out-of-network]	

C BENEFIT INVESTIGATION RESULTS

IV

Access Options	Entyvio IV Infusion Benefits
Covered as:	[Major Medical/Prescription]
Is Entyvio IV Covered?	[Covered/Prior Authorization Required/Not Covered]
Is the Administration Covered?	[Covered/Not Covered]
Coinsurance/Co-pay	[Coinsurance/copay]
Deductible	[$xx.xx - $xx.xx met]
Out-of-Pocket Maximum	[$xx.xx - $xx.xx met]
Annual Maximum	[$xx.xx - $xx.xx met]

D PRIOR AUTHORIZATION NEXT STEPS (IF APPLICABLE)

[patient PA FUNs]

E ADDITIONAL INFORMATION

[patient FUNs]

C BENEFIT INVESTIGATION RESULTS

SC

Access Options	Entyvio IV Infusion Benefits	Entyvio SubC Injection Benefits
Covered as:	[Major Medical/Prescription]	Prescription
Is Entyvio SubC Covered?	[Covered/Prior Authorization Required/Not Covered]	[Covered/Prior Authorization Required/Not Covered]
Is the Administration Covered?	[Covered/Not Covered]	N/A (Self-injectable)
Coinsurance/Co-pay	[Coinsurance/copay]	[Coinsurance/copay]
Deductible	[$xx.xx - $xx.xx met]	[$xx.xx - $xx.xx met]
Out-of-Pocket Maximum	[$xx.xx - $xx.xx met]	[$xx.xx - $xx.xx met]
Annual Maximum	[$xx.xx - $xx.xx met]	[$xx.xx - $xx.xx met]

A Patient Information

Pertinent patient information and health insurance details.

B Physician Information

Contact details and network status.

C Benefit Investigation Results

This section includes information on:

- **Coverage**: Includes how the drug is administered and whether a PA is needed
- Out-of-Pocket costs: Includes **Co-pay/ Coinsurance**, **Deductible**, **Out-of-Pocket Maximum**, and **Annual Maximum**

D Prior Authorization Next Steps

Additional information related to submitting a PA, if applicable.

E Additional Information

Summarizes key points from all of the sections contained in this document. Typical information might include how to find a PA form, how to check the policy for additional information, whether a certain specialty pharmacy should be used for the Entyvio Pen, whether the patient is registered in the Co-Pay Program, and the associated Co-Pay Program member ID.

ID=identification; IV=intravenous; PA=prior authorization; SC=subcutaneous.

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Example of Completed Benefit Verification Form

SAMPLE ONLY

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PATIENT INFORMATION

Patient Name: John Doe	Patient DOB: 01-01-1980	SR ID#: 00001
Insurance: Health Plan ABC		Plan Type: Commercial
Policy ID: HP00123		Plan Renewal Date: 01-01-2024

PHYSICIAN INFORMATION

Physician: Dr. Jack Jones	Phone: (888) 123-4567	Fax: (888) 123-4568
Facility: Main Street GI Clinic		Network Status: In-network

BENEFIT INVESTIGATION RESULTS

Access Options	Entyvio IV Infusion Benefits	Entyvio SubC Injection Benefits
Covered as:	Major Medical	Prescription
Is Entyvio SubC Covered?	Covered	Covered
Is the Administration Covered?	Covered	N/A (Self-injectable)
Coinsurance/Co-pay	Coinsurance	
Deductible	$2,000; $1,500 met	
Out-of-Pocket Maximum	$2,000; $1,500 met	
Annual Maximum	$2,000; $1,500 met	

PRIOR AUTHORIZATION NEXT STEPS (IF APPLICABLE)

N/A

ADDITIONAL INFORMATION

Health plan requires a PA that can be retrieved at www.healthplanABC/PA. Patient is eligible for co-pay support and has been enrolled. Member ID is 12345678910

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