

Entyvio IV (vedolizumab)
Effective 10/01/2024

Plan	<input type="checkbox"/> MassHealth UPPL <input checked="" type="checkbox"/> Commercial/Exchange	Program Type	<input checked="" type="checkbox"/> Prior Authorization <input checked="" type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
Benefit	<input type="checkbox"/> Pharmacy Benefit <input checked="" type="checkbox"/> Medical Benefit		
Specialty Limitations	N/A		
Contact Information	Medical and Specialty Medications		
	All Plans	Phone: 877-519-1908	Fax: 855-540-3693
	Non-Specialty Medications		
	All Plans	Phone: 800-711-4555	Fax: 844-403-1029
Exceptions	N/A		

Overview

Entyvio (vedolizumab) intravenous (IV) injection is an integrin receptor antagonist indicated in adults for the treatment of:

- Moderately to severely active ulcerative colitis (UC)
- Moderately to severely active Crohn’s disease (CD)

Coverage Guidelines

Authorization may be granted for members new to the plan within the past 90 days who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer’s patient assistance program

OR

Authorization may be granted if the member meets all the following diagnosis-specific criteria and documentation has been submitted:

Moderately to severely active Ulcerative Colitis (UC)

1. The member has a diagnosis of moderately to severely active ulcerative colitis (UC)
2. ONE of the following:
 - a. Greater than 6 stools per day
 - b. Frequent blood in stools
 - c. Frequent urgency
 - d. Presence of ulcers
 - e. Abnormal lab values (e.g., hemoglobin, ESR, CRP)
 - f. Dependent on, or refractory to, corticosteroids
3. Member has had trial and failure, intolerance, or contraindication to ONE of the following conventional therapies:
 - a. 6-mercaptopurine
 - b. Aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine)
 - c. Azathioprine
 - d. Corticosteroids (e.g., prednisone)

Moderately to severely active Crohn's Disease (CD)

1. The member has a diagnosis of moderately to severely active Crohn's Disease (CD)
2. ONE of the following:
 - a. Frequent diarrhea and abdominal pain
 - b. At least 10% weight loss
 - c. Complications such as obstruction, fever, abdominal mass
 - d. Abnormal lab values (e.g., C-reactive protein [CRP])
 - e. CD Activity Index (CAI) great than 220
 - f. Fistulizing Crohn's disease
3. Member has had trial and failure, intolerance, or contraindication to ONE of the following conventional therapies:
 - a. 6-mercaptopurine
 - b. Azathioprine
 - c. Corticosteroids (e.g., prednisone)
 - d. Methotrexate

Continuation of Therapy

Reauthorization may be granted for members who achieve or maintain positive clinical response with Entyvio as evidenced by low disease activity or improvement in signs and symptoms of the condition.

Limitations

Initial approvals and reauthorizations will be granted for 12 months.

References

1. Entyvio (vedolizumab) [prescribing information]. Deerfield, IL: Takeda Pharmaceuticals America Inc; April 2024.
2. Kornbluth A, Sachar DB, and the Practice Parameters Committee of the American College of Gastroenterology. Ulcerative Colitis Practice Guidelines in Adults. Am J Gastroenterol. 2010; 105:501–523. Available at <http://s3.gi.org/physicians/guidelines/UlcerativeColitis.pdf>. Accessed September 6, 2016.
3. Lichtenstein GR, Hanauer SB, Sandborn WJ, and the Practice Parameters Committee of the American College of Gastroenterology. Management of Crohn's disease in adults. Am J Gastroenterol. 2009. Available at <http://s3.gi.org/physicians/guidelines/CrohnsDiseaseinAdults2009.pdf>. Accessed September 6, 2016.
4. Loftus EV Jr, Colombel JF, Feagan BG, et al. Long-term Efficacy of Vedolizumab for Ulcerative Colitis. J Crohns Colitis 2017; 11:400
5. Sandborn WJ, Feagan BG, Rutgeerts P, et al. Vedolizumab as induction and maintenance therapy for Crohn's disease. N Engl J Med 2013; 369:711.
6. Talley NJ, Abreu MT, Achkar J, et al. An evidence-based systematic review on medical therapies for inflammatory bowel disease. Am J Gastroenterol. 2011;106(Suppl 1): S2-S25.

Review History

02/23/15 – Reviewed

02/22/16 – Reviewed in P&T Meeting

02/27/17 – Reviewed and revised (adopted ST)

02/26/18 – Reviewed and revised

02/20/19 – Reviewed and revised in P&T Meeting

10/31/2020 – Reviewed; Updated criteria to have preferred agent for Comm/Exch strategy.

12/13/2023 – Reviewed and Updated for Dec P&T; Removed “must meet all initial criteria” for reauthorizations. Effective 1/1/2024



4/10/2024 – Reviewed and Updated for April P&T; Added new agent Entyvio SC to criteria. Added examples of disease progression. Removed Appendix. Added preferred agents. Effective 6/1/2024
09/11/2024 – Reviewed and updated for September P&T. Created separate policies for Entyvio IV and SC formulations. Removed biologic step through requirements for IV. Updated verbiage for Crohn’s disease to specify the condition is moderately to severely active. Updated policy to indicate that Entyvio IV is restricted to the medical benefit. Effective 10/1/2024.

