Mass General Brigham
Health Plan

Velsipity (etrasimod)
Effective 07/01/2025

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	**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			

Overview
Velsipity (etrasimod) is indicated for the treatment of moderately to severely active ulcerative colitis in adults.

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 programs
OR
Authorization may be granted when all the following diagnosis-specific criteria are met:

Moderately to severely active ulcerative colitis
1. Diagnosis of moderately to severely active ulcerative colitis
2. ONE of the following:
    a. Member has had trial and failure, intolerance, or contraindication to ONE of the following conventional therapies:
        i. 6-mercaptopurine
        ii. Aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine)
        iii. Azathioprine
        iv. Corticosteroids (e.g., prednisone)
    b. Disease severity warrants systemic biologic as first-line therapy
3. Trial and failure, intolerance, or contraindication to TWO of the following:
    a. Humira (Abbvie), Hadlima, Adalimumab-adaz, Adalimumab-fkjp, Amjevita (Nuvaila)
    b. Omvoh
    c. Simponi
    d. Skyrizi
    e. Stelara, Wezlana
    f. Rinvoq
    g. Tremfya

h. Xeljanz/XR

4. Trial and failure, intolerance, or contraindication to Zeposia

Continuation of Therapy

Requests for reauthorization will be approved when the following criteria are met:

1. Documentation is submitted supporting improvement in member's condition as evidenced by low disease activity or improvement in signs and symptoms of the condition.

Limitations

1. Initial approvals will be granted for 6 months
2. Reauthorizations will be granted for 12 months.
3. The following quantity limitations apply:

Drug Name and Dosage Form	Quantity Limit
Velsipity 2mg tablet	1 tablet per day

References

1. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA clinical practice guidelines on the management of moderate to severe ulcerative colitis. Gastroenterol. 2020;158:1450-1461.
2. Rubin DT, Ananthakrishnan AN, Siegel CA, et al. ACG clinical guideline: ulcerative colitis in adults. Am J Gastroenterol. 2019;114:384-413.
3. Velsipity (etrasimod) [prescribing information]. New York, NY: Pfizer Labs; June 2024.

Review History

3/10/2024- Created and Reviewed at March P&T, Effective 4/1/2024
09/11/2024 – Reviewed and updated at September P&T. Updated diagnosis language. Removed specialist prescriber requirement. Updated criteria to include Skyrizi as a previous treatment option. Effective 12/1/2024.
10/09/2024 – Reviewed and updated at October P&T. Effective 12/1/2024: updated biologic step criteria to no longer require submission of documentation. Effective 1/1/2025: added Amjevita (Nuvaila) as a preferred adalimumab product. Added Omvoh, Tremfya and Wezlana as preferred biologic step options. Added Zeposia as a required biologic step. Updated reauthorization criteria to require documentation of improvement in member's condition.
05/14/2025 – Reviewed and updated at May P&T. Updated criteria for ulcerative colitis to remove disease characteristic requirement and allow for approval if disease severity warrants systemic biologic as first-line therapy. Effective 07/01/2025.