

Velsipity (etrasimod)
Effective 09/01/2025

Plan	<input type="checkbox"/> MassHealth UPPL <input checked="" type="checkbox"/> Commercial/Exchange	Program Type	<input checked="" type="checkbox"/> Prior Authorization
Benefit	<input checked="" type="checkbox"/> Pharmacy Benefit <input type="checkbox"/> Medical Benefit		<input type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
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
Contact Information	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

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 and reauthorizations will be granted for 24

2. The following quantity limitations apply:

Drug	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.

06/11/2025 – Reviewed and updated at June P&T. Removed immunomodulator step requirements and extended approval duration. Effective 09/01/2025.

