Mass General Brigham
Health Plan

Velsipity (etrasimod)
Effective 05/01/2026

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	**Medical Benefit** **Pharmacy Benefit**	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029
Exceptions	N/A		

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

Coverage Guidelines
If member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days), submission of medical records documenting that the member is currently receiving treatment with the requested drug, 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

<u>Continuation of Therapy</u>
Requests for reauthorization will be approved when the following criteria are met:
1. Submission of medical records (e.g., chart notes) demonstrating improvement in the 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 months
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.
03/11/2026 – Reviewed and updated for March P&T. Administrative update - changing verbiage in reauthorization criteria from "documentation is submitted" to "submission of medical records (e.g., chart notes…" and updating language for members who are new to the Plan. Effective 05/01/2026.