



**Entyvio® (vedolizumab)**  
Effective 03/01/2023

<b>Plan</b>	<input checked="" type="checkbox"/> MassHealth <input type="checkbox"/> Commercial/Exchange	<b>Program Type</b>	<input checked="" type="checkbox"/> Prior Authorization
<b>Benefit</b>	<input checked="" type="checkbox"/> Pharmacy Benefit <input checked="" type="checkbox"/> Medical Benefit (NLX)		<input type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
<b>Specialty Limitations</b>	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
<b>Contact Information</b>	<b>Specialty Medications</b>		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	<b>Non-Specialty Medications</b>		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	<b>Medical Specialty Medications (NLX)</b>		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
<b>Exceptions</b>	N/A		

**Overview**

Entyvio® (vedolizumab) is an integrin receptor antagonist indicated for Adult Ulcerative Colitis (UC) and Adult Crohn's Disease (CD).

**Coverage Guidelines**

Authorization may be reviewed on a case by case basis for members who are new to the plan currently receiving treatment with requested medication excluding when the product is obtained as samples or via manufacturer's patient assistance programs.

**OR**

Authorization may be granted for members when all the following criteria are met, and documentation is provided:

**Ulcerative Colitis (UC)**

Prescriber provides documentation of **ALL** of the following:

1. Diagnosis of moderate to severe ulcerative colitis
2. Appropriate dosing

**Crohn's Disease (CD)**

Prescriber provides documentation of **ALL** of the following:

1. Diagnosis of moderate to severe Crohn's disease
2. Appropriate dosing
3. **For a diagnosis of fistulizing Crohn's disease**, an inadequate response, adverse reaction or contraindication to Avsola® (infliximab-axxq), Remicade® (infliximab), Inflectra® (infliximab-dyyb) or Renflexis® (infliximab-abda) should be documented.



### **Continuation of Therapy**

Resubmission by prescriber will infer a positive response to therapy and request can be recertified if dosing is appropriate.

### **Limitations**

1. Initial approvals will be granted for 6 months.
2. Reauthorizations will be granted for 12 months.

### **Appendix A: Dosing**

	<b>Dosing</b>
Entyvio® (vedolizumab)	<b>Crohn's disease, ulcerative colitis:</b> <u>Initial:</u> 300 mg IV at weeks 0, 2 and 6  <u>Maintenance:</u> 300 mg IV every 8 weeks.

### **References**

1. Entyvio (vedolizumab) [prescribing information]. Deerfield, IL: Takeda Pharmaceuticals America Inc; February 2018.
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. 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.
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. Loftus EV Jr, Colombel JF, Feagan BG, et al. Long-term Efficacy of Vedolizumab for Ulcerative Colitis. J Crohns Colitis 2017; 11:400

### **Review History**

02/23/15 – Reviewed

02/22/16 – Reviewed

02/27/17 – Reviewed and revised (adopted ST) in P&T Meeting

03/01/18 – Reviewed and revised (adopted MH RS) and Effective

02/20/19 – Reviewed in P&T Meeting

01/11/2023 – Reviewed and updated for Jan P&T. Matched MH UPPL. Appropriate diagnosis was replaced with a specific indication throughout. Clarified reauth criteria and initial approval duration from 4 to 6 months. Removed trial requirements from UC and CD criteria. Added Avsola as a trial requirement for fistulizing CD. Effective 3/1/23.

### **Disclaimer**



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