# Medical Policy

**Healthcare Services Department**

| Policy Name | Policy Number | Scope |
|---|---|---|
| Vedolizumab (Entyvio) | MP-RX-FP-28-23 | ☒ MMM MA ☒ MMM Multihealth |

## Service Category

☐ Anesthesia
☐ Surgery
☐ Radiology Procedures
☐ Pathology and Laboratory Procedures
☐ Medicine Services and Procedures
☐ Evaluation and Management Services
☐ DME/Prosthetics or Supplies
☒ Part B Drugs

## Service Description

This document addresses the use of **Vedolizumab (Entyvio)** , a drug approved by the Food and Drug Administration (FDA) for the treatment of Crohn's disease and ulcerative colitis.

**Background Information**

Crohn's Disease: According to the American Gastrointestinal Association clinical practice guidelines, evidence supports the use of methotrexate, corticosteroids, tumor necrosis factor inhibitors (TNFi) +/- immunomodulator, ustekinumab, or vedolizumab for induction of remission. Among the biologics, infliximab, adalimumab, ustekinumab, or vedolizumab are recommended or suggested over certolizumab for induction of remission. Evidence supports biologic agents, thiopurines, and methotrexate for maintenance of remission. Ustekinumab and vedolizumab are options for individuals with primary nonresponse to initial treatment with TNFi. Adalimumab, ustekinumab, or vedolizumab may be used in cases where an individual previously responded to infliximab and then lost response (secondary nonresponse).

Ulcerative Colitis: For those with moderately to severely active disease, the American College of Gastroenterology (ACG) guidelines strongly recommend induction of remission using oral budesonide MMX, oral systemic corticosteroids, TNFi, tofacitinib or vedolizumab (moderate to high quality evidence). The American Gastroenterological Association (AGA) guidelines define moderate to severe UC as those who are dependent on or refractory to corticosteroids, have severe endoscopic disease activity, or are at high risk of colectomy. AGA strongly recommends biologics (TNFi, vedolizumab, or ustekinumab) or tofacitinib over no treatment in induction and maintenance of remission (moderate quality of evidence). For biologic-naïve individuals, Infliximab or vedolizumab are conditionally recommended over adalimumab for induction of remission (moderate quality evidence).

Pediatric Use: Two publications (Conrad 2016, Singh 2016) describe the safety and efficacy of Entyvio (vedolizumab) in pediatric individuals with Crohn's disease or ulcerative colitis who had failed prior treatment with conventional therapy or one or more TNFi. Based on the available peer-reviewed literature and views of relevant medical specialists practicing in pediatrics and pediatric gastroenterology, the use of vedolizumab to induce or maintain remission may be considered a treatment option in a subset of the pediatric population 6 years of age or older with Crohn's disease or ulcerative colitis who are refractory to treatment with conventional drug therapy or TNFi.

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Immune-checkpoint Inhibitor Therapy-Related Toxicity: The National Comprehensive Cancer Network (NCCN) guidelines on Management of Immunotherapy-Related Toxicities provide a 2A recommendation for the use of vedolizumab in moderate or severe diarrhea or colitis secondary to immune checkpoint inhibitor therapy. There is no high-quality data provided to support this use.

**Approved Indications**

A. Crohn's disease

B. Ulcerative colitis

**Other Uses**

A. N/A

## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

| HCPCS | Description |
|---|---|
| J3380 | Injection, vedolizumab, 1 mg [Entyvio] |

| ICD-10 | Description |
|---|---|
| K50.00-K50.919 | Crohn's disease (regional enteritis) |
| K51.00-K51.919 | Ulcerative colitis |

## Medical Necessity Guidelines

When a drug is being reviewed for coverage under a member's medical benefit plan or is otherwise subject to clinical review (including prior authorization), the following criteria will be used to determine whether the drug meets any applicable medical necessity requirements for the intended/prescribed purpose.

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

# Entyvio (Vedolizumab)

**A. Criteria For Initial Approval**

i. Crohn's disease (CD) when the following criteria are met:
   a. Individual is 6 years of age or older (Conrad 2016, Singh 2016) with moderate to severe CD; AND
   b. Individual has had an inadequate response to, is intolerant of, or has a contraindication to conventional therapy (such as systemic corticosteroids or immunosuppressants [such as thiopurines or methotrexate]);

**OR**

ii. Ulcerative colitis (UC) when the following criteria are met:
   a. Individual is 6 years of age or older (Conrad 2016, Singh 2016) with moderate to severe UC; AND
   b. Individual has had an inadequate response to, is intolerant of, or has a contraindication to conventional therapy (such as 5-Aminosalicylic acid products, systemic corticosteroids, or immunosuppressants [such as thiopurines]).

**B. Criteria For Continuation of Therapy**

i. There is confirmation of clinically significant improvement or stabilization in clinical signs and symptoms of the disease.

**C. Conditions Not Covered**

*Any other use is considered experimental, investigational, or unproven, including the following (this list may not be all inclusive).*

Requests for Entyvio (vedolizumab) may not be approved for the following:

i. In combination with oral or topical JAK inhibitors, ozanimod, deucravacitinib, or any of the following biologic immunomodulators: Other TNF antagonists, IL-23 inhibitors, IL-17 inhibitors, IL-6 inhibitors, IL-1 inhibitors, vedolizumab, ustekinumab, abatacept, rituximab, or natalizumab; OR
ii. Active, serious infection or a history of recurrent infections; OR
iii. New or worsening neurological signs or symptoms of John Cunningham virus (JCV) infection or risk of progressive multifocal leukoencephalopathy (PML); OR
iv. When the above criteria are not met and for all other indications.

## Limits or Restrictions

A. Therapeutic Alternatives:

This medical policy may be subject to Step Therapy. Please refer to the document published on the MMM Website: https://www.mmm-pr.com/planes-medicos/formulario-medicamentos

B. Quantity Limitations

*Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines. The chart below includes dosing recommendations as per the FDA-approved prescribing information.*

| Drug | Limit |
|---|---|
| Entyvio 300 mg/vial*^ | 1 vial per 56 days (8 weeks) |
| **Exceptions** | |
| *Initiation of therapy for Crohn's Disease (CD) or Ulcerative Colitis (UC): May approve up to 2 (two) additional single-use vials (300 mg/vial) in the first 6 weeks (42 days) of treatment.<br><br>^For CD or UC, may approve increased dosing, up to 1 vial (300 mg) every 4 weeks if the following criteria are met:<br>I. Individual has been treated with standard maintenance dosing (i.e. every 8 weeks) for at least 2 doses or 16 weeks; AND<br>II. The increased dosing is being prescribed by or in consultation with a gastroenterologist; AND<br>III. Individual initially achieved an adequate response to standard maintenance dosing but has subsequently lost response, as determined by the prescriber; OR<br>IV. Individual partially responded but had an inadequate response to standard maintenance dosing as determined by the prescriber; AND<br>V. Symptoms, if present, are not due to active infections or any other gastrointestinal disorder other than the primary disease; AND<br>VI. Requested dosing does not exceed up to one vial (300 mg) every 4 weeks.<br><br>Initial approval duration for increased dosing for CD or UC: 16 weeks<br><br>^Requests for continued escalated dosing for CD or UC may be approved if the following criteria are met:<br>I. Requested dosing does not exceed up to one vial (300 mg) every 4 weeks; AND<br>II. Individual has subsequently regained response or achieved adequate response following increased dosing, as shown by improvement in signs and symptoms of the disease (including but not limited to reduction in stool frequency/bloody stools, improvement abdominal pain, or endoscopic response); AND<br>III. Individual is not experiencing unacceptable adverse effects from increased dosing; AND<br>IV. Individual will be assessed regularly for dose de-escalation.<br><br>Continued approval duration for increased dosing for CD or UC: 6 months<br><br>^For CD or UC, Increased dosing may not be approved for the following:<br>I. Individual has had no response to Entyvio at standard maintenance dosing (i.e. every 8 weeks); OR | |

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| II. | Individual is requesting dose escalation in absence of signs and symptoms of the disease (for example, requesting based on results of therapeutic drug level or anti-drug antibody testing alone). |

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## Reference Information

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2. DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm. Accessed: October 27, 2022.
3. DrugPoints® System [electronic version]. Truven Health Analytics, Greenwood Village, CO. Updated periodically.
4. Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2022; Updated periodically.
5. Feuerstein JD, Ho EY, Shmidt E et al. American Gastroenterological Association Clinical Practice Guidelines on the Medical Management of Moderate to Severe Luminal and Perianal Fistulizing Crohn's Disease. Gastroenterology 2021; 160:2496-2508.
6. Feuerstein JD, Issacs KL, Schneider Y, et al. American Gastroenterological Association Clinical Practice Guidelines on the Management of Moderate to Severe Ulcerative Colitis. Gastroenterology 2020; 158:1450-1461.
7. Lichtenstein GR, Loftus EV, Isaacs KL et al. 2018 American College of Gastroenterology Guideline for the management of Crohn's disease in adults. Am J Gastroenterol 2018; 113:481–517.
8. Rubin DT, Ananthakrishnan AN, Siegel CA et al. American College of Gastroenterology Clinical Guideline: Ulcerative Colitis in Adults. Am J Gastroenterol 2019; 114:384-413.
9. Conrad MA, Stein RE, Maxwell EC, et al. Vedolizumab therapy in severe pediatric inflammatory bowel disease. Inflamm Bowel Dis. 2016; 22(10):2425-2431.
10. Singh N, Rabizadeh S, Jossen J, et al. Multi-center experience of vedolizumab effectiveness in pediatric inflammatory bowel disease. Inflamm Bowel Dis. 2016; 22(9):2121-2126

Federal and state laws or requirements, contract language, and Plan utilization management programs or polices may take precedence over the application of this clinical criteria.

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## Policy History

| Revision Type | Summary of Changes | P&T Approval Date | MPCC Approval Date |
|---|---|---|---|
| Policy Inception | Elevance Health's Medical Policy adoption. | N/A | 11/30/2023 |

Revised: 11/18/2022