

## **Clinical Policy: Vedolizumab (Entyvio)**

Reference Number: CP.PHAR.265

Effective Date: 07.16

Last Review Date: 05.18

Line of Business: Medicaid

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Vedolizumab (Entyvio<sup>®</sup>) is an integrin receptor antagonist.

### **FDA Approved Indication(s)**

Entyvio is indicated for the treatment of:

- Adult ulcerative colitis
  - Adult patients with moderately to severely active UC who have had an inadequate response with, lost response to, or were intolerant to a tumor necrosis factor (TNF) blocker or immunomodulator; or had an inadequate response with, were intolerant to, or demonstrated dependence on corticosteroids:
    - Inducing and maintaining clinical response,
    - Inducing and maintaining clinical remission,
    - Improving the endoscopic appearance of the mucosa, and
    - Achieving corticosteroid-free remission.
- Adult Crohn's disease
  - Adult patients with moderately to severely active CD who have had an inadequate response with, lost response to, or were intolerant to a TNF blocker or immunomodulator; or had an inadequate response with, were intolerant to, or demonstrated dependence on corticosteroids:
    - Achieving clinical response,
    - Achieving clinical remission, and
    - Achieving corticosteroid-free remission.

### **Policy/Criteria**

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

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Entyvio is **medically necessary** when the following criteria are met:

#### **I. Initial Approval Criteria**

##### **A. Ulcerative Colitis** (must meet all):

1. Diagnosis of UC;
2. Prescribed by or in consultation with a gastrointestinal (GI) specialist;
3. Age  $\geq$  18 years;

4. Failure of a  $\geq 3$  consecutive month trial of azathioprine, 6-mercaptopurine (6MP), or an aminosalicylate (e.g., sulfasalazine) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
5. Failure of a  $\geq 3$  consecutive month trial of adalimumab (*Humira*<sup>®</sup> is preferred) AND one other TNF blocker indicated for UC (e.g., infliximab [*Inflixtra*<sup>®</sup> and *Renflexis*<sup>™</sup> are preferred]), unless contraindicated or clinically significant adverse effects are experienced;  
*\*Prior authorization is required for adalimumab and all TNF blockers*
6. Dose does not exceed 300 mg at weeks 0, 2, and 6, followed by maintenance dose of 300 mg every 8 weeks.

**Approval duration: 6 months**

**B. Crohn's Disease (must meet all):**

1. Diagnosis of CD;
2. Prescribed by or in consultation with a GI specialist;
3. Age  $\geq 18$  years;
4. Failure of a  $\geq 3$  consecutive month trial of at least ONE immunomodulator (e.g., azathioprine, 6MP, methotrexate [MTX]) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
5. Failure of a  $\geq 3$  consecutive month trial of adalimumab (*Humira* is preferred) AND one other TNF blocker (e.g., infliximab [*Inflixtra* and *Renflexis* are preferred], Cimzia<sup>®</sup>), unless contraindicated or clinically significant adverse effects are experienced;  
*\*Prior authorization is required for adalimumab and all TNF blockers*
6. Dose does not exceed 300 mg at weeks 0, 2, and 6, followed by maintenance dose of 300 mg every 8 weeks.

**Approval duration: 6 months**

**C. Other diagnoses/indications**

1. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

**II. Continued Therapy**

**A. All Indications in Section I (must meet all):**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 300 mg every 8 weeks.

**Approval duration: 12 months**

**B. Other diagnoses/indications (must meet 1 or 2):**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.  
**Approval duration: Duration of request or 6 months (whichever is less);** or
2. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

**III. Diagnoses/Indications for which coverage is NOT authorized:**

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

6-MP: 6-mercaptopurine

CD: Crohn’s disease

FDA: Food and Drug Administration

GI: gastrointestinal

MTX: methotrexate

TNF: tumor necrosis factor

UC: ulcerative colitis

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.*

| Drug Name   | Dosing Regimen   | Dose Limit/<br>Maximum Dose |
|---|--|-----------------------------|
| azathioprine<br>(Azasan <sup>®</sup> ,<br>Imuran <sup>®</sup> ) | <b>CD*, UC*</b><br>1.5 – 2 mg/kg/day PO  | 2.5 mg/kg/day               |
| corticosteroids   | <b>CD*</b><br>prednisone 40 mg PO QD for 2 weeks or<br>IV 50 – 100 mg Q6H for 1 week<br><br>budesonide (Entocort EC <sup>®</sup> ) 6 – 9 mg PO<br>QD | N/A                         |
| 6-mercaptopurine<br>(Purixan <sup>®</sup> )                     | <b>CD*, UC*</b><br>50 mg PO QD or 1 – 2 mg/kg/day PO   | 2 mg/kg/day                 |
| mesalamine<br>(Pentasa <sup>®</sup> )                           | <b>CD, UC</b><br>1,000 mg PO QID   | 4 g/day                     |
| sulfasalazine<br>(Azulfidine <sup>®</sup> )                     | <b>UC</b><br><u>Initial dose</u><br>3 – 4 g/day PO in divided doses (not to<br>exceed Q8 hrs)<br><u>Maintenance dose</u><br>2g PO QD                 | 4g/day                      |
| Cimzia <sup>®</sup><br>(certolizumab)                           | <b>CD</b><br><u>Initial dose:</u> 400 mg SC at 0, 2, and 4<br>weeks<br><u>Maintenance dose:</u> 400 mg SC every 4<br>weeks                           | 400 mg every 4 weeks        |

| Drug Name  | Dosing Regimen   | Dose Limit/<br>Maximum Dose                                 |
|--|--|---|
| Humira <sup>®</sup><br>(adalimumab)                                | <b>CD, UC</b><br><u>Initial dose:</u><br>160 mg SC on Day 1, then 80 mg SC on Day 15<br><br><u>Maintenance dose:</u><br>40 mg SC every other week starting on Day 29   | 40 mg every other week                                      |
| Renflexis <sup>®</sup> ,<br>Inflectra <sup>®</sup><br>(infliximab) | <b>CD</b><br><u>Initial dose:</u><br>5 mg/kg IV at weeks 0, 2 and 6<br><u>Maintenance dose:</u><br>5 mg/kg IV every 8 weeks.<br><br>Some adult patients who initially respond to treatment may benefit from increasing the dose to 10 mg/kg if they later lose their response<br><br><b>UC</b><br><u>Initial dose:</u><br>5 mg/kg IV at weeks 0, 2 and 6<br><u>Maintenance dose:</u><br>5 mg/kg IV every 8 weeks | CD: 10 mg/kg every 8 weeks<br><br>UC: 5 mg/kg every 8 weeks |

Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.

\*Off-label

#### Appendix C: General Information

- Definition of failure of MTX or DMARDs
  - Child-bearing age is not considered a contraindication for use of MTX. Each drug has risks in pregnancy. An educated patient and family planning would allow use of MTX in patients who have no intention of immediate pregnancy.
  - Social use of alcohol is not considered a contraindication for use of MTX. MTX may only be contraindicated if patients choose to drink over 14 units of alcohol per week. However, excessive alcohol drinking can lead to worsening of the condition, so patients who are serious about clinical response to therapy should refrain from excessive alcohol consumption.

#### V. Dosage and Administration

| Indication | Dosing Regimen   | Maximum Dose         |
|------------|--|----------------------|
| UC, CD     | <u>Initial dose:</u><br>300 mg IV at weeks 0, 2, and 6 | 300 mg every 8 weeks |

| Indication | Dosing Regimen                                      | Maximum Dose |
|------------|---|--------------|
|            | <u>Maintenance dose:</u><br>300 mg IV every 8 weeks |              |

**VI. Product Availability**

Single-use vial: 300 mg/20 mL

**VII. References**

1. Entyvio Prescribing Information. Deerfield, IL: Takeda Pharmaceuticals America Inc.; February 2018. Available at [www.entyviohcp.com](http://www.entyviohcp.com). Accessed February 27, 2018.
2. 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;104(2):465-483.
3. Kornbluth A, Sachar DB. Ulcerative Colitis Practice Guidelines in Adults: American College of Gastroenterology, Practice Parameters Committee. *Am J Gastroenterol.* 2010;105;501-523.
4. Sandborn WJ. Crohn’s Disease Evaluation and Treatment: Clinical Decision Tool. *Gastroenterology* 2014; 147: 702-705.
5. Dassopoulos T, Cohen R, Scherl E, et al. Ulcerative Colitis Clinical Care Pathway. American Gastroenterological Association. 2015. Available at <http://campaigns.gastro.org/algorithms/UlcerativeColitis/>. Accessed February 27, 2018.
6. Ordas I, Feagan BG, Sandborn WJ. Early use of immunosuppressives or TNF antagonists for the treatment of Crohn's disease: time for a change. *Gut.* 2011 Dec; 60(12):1754-63.
7. Bernell O, Lapidus A, Hellers G. Risk Factors for Surgery and Postoperative Recurrence in Crohn’s Disease. *Annals of Surgery.* 2000; 231(1): 38-45.

**Coding Implications –**

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

| HCPCS Codes | Description                  |
|-------------|------------------------------|
| J3380       | Injection, vedolizumab, 1 mg |

| Reviews, Revisions, and Approvals   | Date  | P&T Approval Date |
|---|-------|-------------------|
| Policy split from CP.PHAR.87.IBD Treatment_4_.<br>CD/UC: removed criteria related to concomitant use with other biologics, and concurrent administration of live; added dosing; added requirement for trial and failure of PDL Humira as one of the two required TNF inhibitors, unless contraindicated.<br>CD: added poor prognostic indicators; modified criteria requiring failure of immunomodulator, corticosteroids or aminosalicylate to | 06.16 | 07.16             |

| Reviews, Revisions, and Approvals   | Date     | P&T Approval Date |
|---|----------|-------------------|
| failure of “corticosteroid, with or without immunomodulator” per 2014 AGA Clinical decision tool.<br>Re-auth: added criteria related to dosing per PI and reasons to discontinue. Modified approval duration to 6 months initial and 12 months for renewal.   |          |                   |
| Removed trial and failure of corticosteroid as an option for moderate to severe CD, per 2014 AGA Clinical decision tool- corticosteroids are appropriate for low-risk patients. UC: removed option of trial of aminosalicylates per 2015 AGA Clinical Care Pathway.   | 11.16    |                   |
| Converted to new template. UC: removed Cimzia as example of second TNF for redirection as Cimzia is not indicated for UC; change required trials from immunomodulator to specifically thiopurines based on AGA and ACG guidelines and removed MTX as example of acceptable trial.<br>Clarified immunomodulator redirection for maintenance requests for all indications. CD: modified poor prognostic indicator list to match AGA guidelines. Safety criteria revised according to the safety guidance discussed at CPAC and endorsed by Centene Medical Affairs. | 07.17    | 07.17             |
| CD: Reclassified “failure of an immunomodulator...” as one of the options to meet criteria point 1 (along with other poor prognostic indicators), instead of as an alternative to failing Humira and another TNF inhibitor in criteria point 2.   | 08.17    |                   |
| 2Q 2018 annual review: modified gastroenterologist specialty requirement to gastrointestinal specialist; modified trial and failure of all agents for all conditions to have duration of at least 3 consecutive months; added aminosalicylate as an option for trial and failure for UC; specified brand names for preferred trial and failure agents in all conditions; removed specific diagnosis requirements for CD; references reviewed and updated.   | 02.27.18 | 05.18             |

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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**Note:**

**For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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