Montana Healthcare Programs
Physician Administered Drug Coverage Criteria

ENTYVIO® (vedolizumab)

Criteria Update Effective: July 22, 2021

I. Medication Description

Entyvio® is an integrin receptor antagonist indicated in adults for the treatment of:

- Moderately to severely active ulcerative colitis.
- Moderately to severely active Crohn's disease.

II. Position Statement

Coverage is determined through a prior authorization process **that must include** supporting clinical documentation for each request.

III. Initial Coverage Criteria

Crohn's Disease

Member must meet all the following criteria:

- Member is 18 years of age or older.
- Member must have a diagnosis of moderately to severely active Crohn's disease.
- Medication is prescribed by or in consult with an appropriate specialist (gastroenterologist).
- Member must have had an inadequate response with lost response to or was intolerant to a Montana Healthcare Programs preferred TNF blocker (e.g., Humira®), unless contraindicated.

Ulcerative Colitis

Member must meet all the following criteria:

- Member is 18 years of age or older.
- Member must have a diagnosis of moderately to severely active ulcerative colitis.
- Medication is prescribed by or in consult with an appropriate specialist (gastroenterologist).

IV. Renewal Coverage Criteria

Member must meet all the following criteria:

- Member has been adherent to Entyvio®.
- Member has experienced a positive clinical response.
- Annual specialist consult provided if prescriber not a specialist**.**

V. Quantity Limitations

Max 300mg IV at 0, 2, and 6 weeks, then every 8 weeks thereafter.

VI. Coverage Duration

Initial approval duration: 14 weeks (1200mg)
Renewal approval duration: 1 year