Entyvio (vedolizumab)
Effective 02/20/19

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<th>Plan</th>
<th>Benefit</th>
<th>Program Type</th>
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<td>☒ Commercial/Exchange</td>
<td>☒ Prior Authorization</td>
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<td>☒ Pharmacy Benefit</td>
<td>☐ Medical Benefit (NLX)</td>
<td>☐ Quantity Limit</td>
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<td>☐ Quantity Limit</td>
<td>☐ Step Therapy</td>
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Specialty Limitations
This medication has been designated specialty and must be filled at a contracted specialty pharmacy.

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<th>Contact Information</th>
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<th>Non-Specialty Medications</th>
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<tr>
<td>All Plans</td>
<td>Phone: 866-814-5506</td>
<td>Phone: 877-433-7643</td>
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<td></td>
<td>Fax: 866-249-6155</td>
<td>Fax: 866-255-7569</td>
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<td>-commercial/Exchange</td>
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<td>Phone: 800-294-5979</td>
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<td>Fax: 888-836-0730</td>
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<td>Exchange</td>
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<td>Phone: 855-582-2022</td>
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<td>Fax: 855-245-2134</td>
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Medical Specialty Medications (NLX)
All Plans | Phone: 844-345-2803 | Fax: 844-851-0882

Exceptions
N/A

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

Coverage Guidelines
Moderately to severely active Ulcerative Colitis (UC)
Authorization may be granted for members who are currently receiving treatment with Entyvio excluding when the product is obtained as samples or via manufacturer’s patient assistance programs.
OR
Authorization may be granted for members who have had inadequate response, intolerance, or contraindication to BOTH of the following:
1. Humira (adalimumab)
2. ONE conventional therpay option (See Appendix A)

Moderately to severely active Crohn’s Disease (CD)
Authorization may be granted for members who are currently receiving treatment with Entyvio excluding when the product is obtained as samples or via manufacturer’s patient assistance programs.
OR
Authorization may be granted for members who have had inadequate response, intolerance, or contraindication to BOTH of the following:
1. Humira (adalimumab)
2. ONE conventional therpay option (See Appendix B)

Continuation of Therapy
Reauthorization may be granted for members, including those who are new to AllWays Health Partners, who meet ALL initial authorization criteria and achieve or maintain positive clinical response after at least 4 months of therapy with Entyvio as evidenced by low disease activity or improvement in signs and symptoms of the condition.

Limitations
1. Approvals will be granted for 12 months.

Appendices

Appendix A: Examples of Conventional Therapy Options for UC

1. Mild to moderate disease – induction of remission:
   a. Mesalamine (e.g., Asacol, Asacol HD, Lialda, Pentasa)
   b. Rectal mesalamine (e.g., Canasa, Rowasa)
   c. Alternatives: azathioprine, mercaptopurine, sulfasalazine

2. Mild to moderate disease – maintenance of remission:
   a. Oral mesalamine, rectal mesalamine
   b. Alternatives: azathioprine, mercaptopurine, sulfasalazine

3. Severe disease – induction of remission:
   a. Sulfasalazine
   b. Severe disease – maintenance of remission:

4. Azathioprine, mercaptopurine
   a. Alternative: sulfasalazine

5. Pouchitis: rectal mesalamine

Appendix B: Examples of Conventional Therapy Options for CD

1. Mild to moderate disease – induction of remission:
   a. Oral mesalamine (e.g., Asacol, Asacol HD, Lialda, Pentasa)

2. Mild to moderate disease – maintenance of remission:
   a. Azathioprine, mercaptopurine
   b. Alternatives: methotrexate intramuscularly (IM)

3. Moderate to severe disease – induction of remission:
   a. Methotrexate IM

4. Moderate to severe disease – maintenance of remission:
   a. Azathioprine, mercaptopurine
   b. Alternative: methotrexate IM

5. Perianal and fistulizing disease – maintenance of remission
   a. Azathioprine, mercaptopurine
   b. Alternative: methotrexate IM

References
1. Entyvio (vedolizumab) [prescribing information]. Deerfield, IL: Takeda Pharmaceuticals America Inc; February 2018.


Review History
02/23/15 – Reviewed
02/22/16 – Reviewed in P&T Meeting
02/27/17 – Reviewed and revised (adopted ST)
02/26/18 – Reviewed and revised
02/20/19 – Reviewed and revised in P&T Meeting

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