

Montana Healthcare Programs
Physician Administered Drug Coverage Criteria

ENTYVIO® (vedolizumab)

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:

- 18 years of age or older
- Must have a diagnosis of moderately to severely active Crohn's disease
- Medication is prescribed by or in consult with an appropriate specialist (gastroenterologist).
- Must have had an inadequate response with, lost response to or was intolerant to a Montana Healthcare Programs-preferred Tumor Necrosis Factor (TNF) blocker, unless contraindicated.
 - List of Montana Healthcare Programs-preferred drugs can be found at <https://medicaidprovider.mt.gov/19>.

Ulcerative Colitis

Member must meet all the following criteria:

- 18 years of age or older
- 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:

- Has been adherent to Entyvio®
- 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