Drug Coverage Policy

Effective Date.....08/01/2024
Coverage Policy Number..... IP0605
Policy Title.....Velsipity

Inflammatory Conditions – Velsipity

- Velsipity® (etrasimod tablets – Pfizer)

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment and have discretion in making individual coverage determinations. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Medical Necessity Criteria

Velsipity is considered medically necessary when the following criteria is met:

FDA-Approved Indications

1. **Ulcerative Colitis.** Approve for the duration noted if the individual meets ONE of the following (A or B):
   A) Initial Therapy. Approve for 6 months if the individual meets ALL of the following (i, ii, iii, and iv):
      i. Individual is 18 years of age or older; AND

ii. Individual has had a trial of ONE systemic agent for ulcerative colitis; AND
Note: Examples of systemic agents for ulcerative colitis include 6-mercaptopurine, azathioprine, cyclosporine, tacrolimus, or a corticosteroid such as prednisone, methylprednisolone. A trial of one biologic also counts as a trial of one systemic agent for ulcerative colitis. Refer to the Appendix for examples of biologics used for ulcerative colitis.

iii. The medication is prescribed by or in consultation with a gastroenterologist.

iv. Preferred product criteria is met for the products listed in the below table(s) -

B) Individual is Currently Receiving Velsipity. Approve for 1 year if the individual meets ALL of the following (i, and ii):

i. Individual has been established on therapy for at least 6 months; AND
Note: A individual who has received less than 6 months of therapy or who is restarting therapy is reviewed under criterion A (Initial Therapy).

ii. Individual meets at least one of the following (a or b):

a) When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline (prior to initiating the requested drug); OR
Note: Examples of assessment for inflammatory response include fecal markers (e.g., fecal calprotectin), serum markers (e.g., C-reactive protein), endoscopic assessment, and/or reduced dose of corticosteroids.

b) Compared with baseline (prior to initiating Velsipity), patient experienced an improvement in at least one symptom, such as decreased pain, fatigue, stool frequency, and/or decreased rectal bleeding.

Employer Plans:

Product	Criteria
Velsipity (etrasimod)	Documentation of **ONE** of the following (1 or 2): 1. Failure, contraindication, or intolerance to **BOTH** of the following (A and B): A. **TWO** of the following (i, ii, iii): **i.** **Adalimumab Product** (**adalimumab-adaz/Hyrimoz** [by Sandoz/Novartis], **adalimumab – adbm/Cyltezo**, **adalimumab-ryvk/Simlandi**, or **Humira** [by AbbVie]) [requires prior authorization] **ii.** **Stelara SC** [requires prior authorization] **iii.** **Zymfentra** [requires prior authorization] B. **Zeposia** [requires prior authorization] 2. Currently receiving Velsipity for at least 90 days

Individual and Family Plans:

Product	Criteria
Velsipity (etrasimod)	Documentation of **ONE** of the following (1 or 2): 1. Failure, contraindication, or intolerance to **BOTH** of the following (A and B): A. **Adalimumab Product** (**adalimumab-adaz/Hyrimoz** [by Sandoz/Novartis], **adalimumab – adbm/Cyltezo**, **adalimumab-ryvk/Simlandi**, or **Humira** [by AbbVie]) [requires prior authorization] B. **Stelara SC** [requires prior authorization] 2. Currently receiving Velsipity for at least 90 days

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Conditions Not Covered

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

1. **Concurrent Use with a Biologic or with a Targeted Synthetic Disease-Modifying Antirheumatic Drug (DMARD) for Ulcerative Colitis.** In the pivotal trials, patients who received Velsipity were not permitted to receive concomitant treatment with biologics used for the treatment of ulcerative colitis (see Appendix for examples).[1] Combination therapy is generally not recommended due to a potential for a higher rate of adverse effects with combinations and lack of evidence supporting additive efficacy. There are no data evaluating combination of Velsipity with a targeted synthetic DMARD (e.g., Xeljanz/Xeljanz XR (tofacitinib tablets/extended-release tablets); therefore, safety and efficacy of this combination is unknown.

Background

OVERVIEW
Velsipity, a sphingosine 1-phosphate receptor modulator, is indicated for the treatment of **ulcerative colitis** (UC), in adults with moderately to severely active disease.[1]

Guidelines/Clinical Efficacy
Velsipity is not currently addressed in UC guidelines. The American Gastroenterological Association (2020) and the American College of Gastroenterology (2019) have clinical practice guidelines on the management of moderate to severe UC and make recommendations for induction and maintenance of remission in adults.[2,3] Both endorse the use of biologic agents and give specific patient circumstances in the selection for induction and maintenance therapies. Pivotal trials for Velsipity included adults with moderately to severely active UC who had an inadequate response or were intolerant to any of the following agents: oral aminosalicylates, corticosteroids, immunomodulators (e.g., 6-mercaptopurine and azathioprine), or a biologic (e.g., tumor necrosis factor inhibitor, Entyvio® [vedolizumab injection], or a Janus kinase inhibitor (e.g., Xeljanz® [tofacitinib tablets]).[1]

Appendix

	Mechanism of Action	Examples of Inflammatory Indications*
Biologics		
Adalimumab SC Products (Humira®, biosimilars)	Inhibition of TNF	AS, CD, JIA, PsO, PsA, RA, UC
Cimzia® (certolizumab pegol SC injection)	Inhibition of TNF	AS, CD, nr-axSpA, PsO, PsA, RA
Etanercept SC Products (Enbrel®, biosimilars)	Inhibition of TNF	AS, JIA, PsO, PsA

Infliximab IV Products (Remicade®, biosimilars)	Inhibition of TNF	AS, CD, PsO, PsA, RA, UC
Zymfentra® (infliximab-dyyb SC injection)	Inhibition of TNF	CD, UC
Simponi®, **Simponi**® **Aria**™ (golimumab SC injection, golimumab IV infusion)	Inhibition of TNF	SC formulation: AS, PsA, RA, UC
		IV formulation: AS, PJIA, PsA, RA
Actemra® (tocilizumab IV infusion, SC injection)	Inhibition of IL-6	SC formulation: PJIA, RA, SJIA
		IV formulation: PJIA, RA, SJIA
Kevzara® (sarilumab SC injection)	Inhibition of IL-6	RA
Orencia® (abatacept IV infusion, SC injection)	T-cell costimulation modulator	SC formulation: JIA, PSA, RA
		IV formulation: JIA, PsA, RA
Rituximab IV Products (Rituxan®, biosimilars)	CD20-directed cytolytic antibody	RA
Kineret® (anakinra SC injection)	Inhibition of IL-1	JIA^, RA
Omvoh® (mirikizumab IV infusion, SC injection)	Inhibition of IL-23	UC
Stelara® (ustekinumab IV infusion, SC injection)	Inhibition of IL-12/23	SC formulation: CD, PsO, PsA, UC
		IV formulation: CD, UC
Siliq™ (brodalumab SC injection)	Inhibition of IL-17	PsO
Cosentyx® (secukinumab SC injection)	Inhibition of IL-17A	AS, ERA, nr-axSpA, PsO, PsA
Taltz® (ixekizumab SC injection)	Inhibition of IL-17A	AS, nr-axSpA, PsO, PsA
Ilumya™ (tildrakizumab-asmn SC injection)	Inhibition of IL-23	PsO
Skyrizi® (risankizumab-rzaa SC injection, risankizumab-rzaa IV infusion)	Inhibition of IL-23	SC formulation: CD, PSA, PsO
		IV formulation: CD
Tremfya™ (guselkumab SC injection)	Inhibition of IL-23	PsO
Entyvio™ (vedolizumab IV infusion, SC injection)	Integrin receptor antagonist	SC: UC
		IV: CD, UC
Oral Therapies/Targeted Synthetic DMARDs		
Otezla® (apremilast tablets)	Inhibition of PDE4	PsO, PsA
Cibinqo™ (abrocitinib tablets)	Inhibition of JAK pathways	AD
Olumiant® (baricitinib tablets)	Inhibition of JAK pathways	RA
Rinvoq® (upadacitinib extended-release tablets)	Inhibition of JAK pathways	AD, AS, nr-axSpA, RA, PsA, UC
Sotyktu™ (deucravacitinib tablets)	Inhibition of TYK2	PsO
Xeljanz® (tofacitinib tablets)	Inhibition of JAK pathways	RA, PJIA, PsA, UC
Xeljanz® XR (tofacitinib extended-release tablets)	Inhibition of JAK pathways	RA, PsA, UC
Zeposia® (ozanimod tablets)	Sphingosine 1 phosphate receptor modulator	UC
Velsipity® (etrasimod tablets)	Sphingosine 1 phosphate receptor modulator	UC

* Not an all-inclusive list of indications (e.g., oncology indications and rare inflammatory conditions are not listed). Refer to the prescribing information for the respective agent for FDA-approved indications; SC – Subcutaneous; TNF – Tumor necrosis factor; AS – Ankylosing spondylitis; CD – Crohn's disease; JIA – Juvenile idiopathic arthritis; PsO – Plaque psoriasis; PsA – Psoriatic arthritis; RA – Rheumatoid arthritis; UC – Ulcerative colitis; nr-axSpA – Non-radiographic axial spondyloarthritis; IV – Intravenous, PJIA – Polyarticular juvenile idiopathic arthritis; IL – Interleukin; SJIA – Systemic juvenile idiopathic arthritis; ^ Off-label use of Kineret in JIA supported in guidelines; ERA – Enthesitis-related arthritis; DMARD – Disease-modifying antirheumatic drug; PDE4 – Phosphodiesterase 4; JAK – Janus kinase; AD – Atopic dermatitis; TYK2 – Tyrosine kinase 2.

References

1. Velsipity® tablets [prescribing information]. New York, NY: Pfizer; October 2023.
2. Feuerstein JD, Isaac s KL, Schneider Y, et al. AGA clinical practice guidelines on the management of moderate to severe ulcerative colitis. *Gastroenterology*. 2020;158:1450-1461.
3. 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.

Revision Details

Type of Revision	Summary of Changes	Date
Selected Revision	Added Zymfentra as a preferred product option, for Ulcerative Colitis, for Employer Plans.	8/1/2024
Selected Revision	Updated Adalimumab preferred product alternatives.	6/1/2024
New	New policy	04/15/2024

The policy effective date is in force until updated or retired.