AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Velsipity	Page:	1 of 3
Effective Date:	5/1/2025	Last Review Date:	4/2025

Applies to:	☐Illinois	☐Florida	☒New Jersey
	☐Maryland	☐Florida Kids	☐Pennsylvania Kids
	☐Michigan	☐ Virginia	☐Kentucky PRMD

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Velsipity under the patient's prescription drug benefit.

Description:

FDA-Approved Indication

Treatment of moderately to severely active ulcerative colitis in adults.

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Velsipity

Policy/Guideline:

Documentation for all Indications:
The patient is unable to take TWO preferred products (a preferred adalimumab product, a preferred ustekinumab product, Rinvoq) due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval.

Documentation

Submission of the following information is necessary to initiate the prior authorization review:

Continuation Requests

Chart notes or medical record documentation supporting positive clinical response to therapy or remission.

Prescriber Specialties
This medication must be prescribed by or in consultation with gastroenterologist.

Coverage Criteria

Ulcerative Colitis[1]

Authorization of 12 months may be granted for treatment of moderately to severely active ulcerative colitis.

Continuation of Therapy[2,3]

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for moderately to severely active ulcerative colitis and who achieve or maintain remission.

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for moderately to severely active ulcerative colitis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

- Stool frequency
- Rectal bleeding
- Urgency of defecation
- C-reactive protein (CRP)
- Fecal calprotectin (FC)
- Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound
- Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo score)

Other

Member cannot use the requested medication concomitantly with immunomodulators, biologic drugs, or targeted synthetic drugs.

Dosage and Administration

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Approval Duration and Quantity Restrictions:

Initial and Renewal Approval: 12 Months

Quantity Level Limit:

- Velsipity (etrasimod) 2 mg film-coated tablets: 30 tablets per 30 days

References:

1. Velsipity [package insert]. New York, NY: Pfizer Inc.; June 2024.

2. Sandborn WJ, Vermeire S, Peyrin-Biroulet L, et al. Etrasimod as induction and maintenance therapy for ulcerative colitis (ELEVATE): two randomized, double-blind, placebo-controlled, phase 3 studies. Lancet. 2023; 410(10383):1159-71.
3. Rubin DT, Ananthakrishnan AN, et al. 2019 ACG Clinical Guideline: Ulcerative Colitis in Adults. Am J Gastroenterol. 2019;114:384-413.
4. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA Clinical Practice Guidelines on the Management of Moderate to Severe Ulcerative Colitis. Gastroenterology. 2020;158:1450-1461.