

PA Criteria	Criteria Details						
Covered Uses (FDA approved indication)	Entyvio is an integrin receptor antagonist indicated for Ulcerative Colitis (UC) and Crohn's Disease (CD).						
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).						
Required Medical Information	Medical records supporting the request must be provided, including documentation of prior therapies and responses to treatment.						
Age Restriction	None.						
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.						
Coverage Duration	Initial coverage: One year. Reauthorization: Two years. Dose will be approved according to the FDA approved labeling or within accepted standards of medical practice.						
Other Criteria/Information	Refer to the Gold Coast Health Plan Medicare Part B Reference and Summary of Evidence document. <table border="1" data-bbox="496 898 1513 1045"> <thead> <tr> <th>HCPCS</th> <th>Description</th> <th>Billing Units/How Supplied</th> </tr> </thead> <tbody> <tr> <td>J3380</td> <td>Entyvio IV (vedolizumab) 300mg vial</td> <td>Billing unit: 1 mg 300 mg SDV</td> </tr> </tbody> </table>	HCPCS	Description	Billing Units/How Supplied	J3380	Entyvio IV (vedolizumab) 300mg vial	Billing unit: 1 mg 300 mg SDV
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STATUS	DATE REVISED	REVIEW DATE	APPROVED/REVIEWED BY	EFFECTIVE DATE
Created	3/26/2025	3/26/2025	Dawn Shojai, PharmD, Senior Pharmacy Benefit Consultant (PSG)	N/A
Approved	N/A	5/15/2025	Pharmacy & Therapeutics (P&T) Committee	5/15/2025