Entyvio® (Vedolizumab) (for Ohio Only)

Policy Number: CSOH2024D0053.A
Effective Date: January 1, 2024

Instructions for Use

Table of Contents **Page**

Related Policies
None

Application

This Medical Benefit Drug Policy only applies to the state of Ohio. Any requests for services that are stated as unproven or services for which there is a coverage or quantity limit will be evaluated for medical necessity using Ohio Administrative Code 5160-1-01.

Coverage Rationale

Entyvio® (vedolizumab) is proven and medically necessary for the treatment of certain conditions outlined within the InterQual® criteria. For medical necessity clinical coverage criteria, refer to the current release of the InterQual® guideline for Entyvio®: CP: Specialty Rx Non-Oncology, Vedolizumab (Entyvio®).

Click here to view the InterQual® criteria.

Applicable Codes

The following list(s) of procedure codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
J3380	Injection, vedolizumab, 1 mg

Policy History/Revision Information

Date	Summary of Changes
01/01/2024	**Template Update** • Created state-specific policy version

Date	Summary of Changes
	Application • Modified language to indicate this Medical Benefit Drug Policy only applies to the state of Ohio; any requests for services that are stated as unproven or services for which there is a coverage or quantity limit will be evaluated for medical necessity using *Ohio Administrative Code 5160-1-01* **Coverage Rationale** • Revised language to indicate Entyvio® (Vedolizumab) is proven and medically necessary for the treatment of certain conditions outlined within the InterQual® criteria; for medical necessity clinical coverage criteria, refer to the current release of the InterQual® CP: Specialty Rx Non-Oncology, Vedolizumab (Entyvio®) **Applicable Codes** • Removed list of applicable ICD-10 diagnosis codes • Removed language pertaining to maximum dosage requirements **Supporting Information** • Removed *Background*, *Clinical Evidence*, *FDA*, and *References* sections • Archived previous policy version CS2022D0053Q

Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state (Ohio Administrative Code [OAC]), or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state (OAC), or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state (OAC), or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state (OAC), or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Benefit Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.