UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1438-2
Program	Prior Authorization/Notification
Medication	Velsipity™ (etrasimod)* *Velsipity is excluded from coverage for the majority of our benefits
P&T Approval Date	4/2024, 4/2025
Effective Date	7/1/2025

1. Background:

Velsipity (etrasimod) is a sphingosine 1-phosphate receptor modulator indicated for the treatment of moderately to severely active ulcerative colitis in adults.

2. Coverage Criteria[a]:

A. Initial Authorization

1. **Velsipity** will be approved based on **both** of the following criteria:

   a. Diagnosis of moderately to severely active ulcerative colitis

   -AND-

   b. Patient is not receiving Velsipity in combination with a targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Entyvio (vedolizumab), Olumiant (baricitinib), Omvoh (mirikizumab-mrkz), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Tremfya (guselkumab), ustekinumab, Xeljanz (tofacitinib)]

   Authorization will be issued for 12 months.

B. Reauthorization

1. **Velsipity** will be approved based on **both** of the following criteria:

   a. Documentation of positive clinical response to Velsipity therapy

   -AND-

   b. Patient is not receiving Velsipity in combination with a targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Entyvio (vedolizumab), Olumiant (baricitinib), Omvoh (mirikizumab-mrkz), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Tremfya (guselkumab), ustekinumab, Xeljanz (tofacitinib)]

   Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Exclusion: Velsipity is excluded from coverage for the majority of our benefits
- Supply limits and/or Step Therapy may be in place.

4. References:

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

Program	Prior Authorization/Notification – Velsipity (etrasimod)
Change Control	
4/2024	New program.
4/2025	Annual review. Updated examples with no change to clinical intent. Updated reference.