Vedolizumab (ENTYVIO) Intravenous Injection in Inflammatory Bowel Disease Criteria for Use June 2025

VA Pharmacy Benefits Management Services and National Formulary Committee

The following recommendations are based on medical evidence, clinician input, and expert opinion. The content of the document is dynamic and will be revised as new information becomes available. The purpose of this document is to assist practitioners in clinical decision-making, to standardize and improve the quality of patient care, and to promote cost-effective drug prescribing. THE CLINICIAN SHOULD USE THIS GUIDANCE AND INTERPRET IT IN THE CLINICAL CONTEXT OF THE INDIVIDUAL PATIENT. INDIVIDUAL CASES THAT ARE EXCEPTIONS TO THE EXCLUSION AND INCLUSION CRITERIA SHOULD BE ADJUDICATED AT THE LOCAL FACILITY ACCORDING TO THE POLICY AND PROCEDURES OF ITS P&T COMMITTEE AND PHARMACY SERVICES.

The Product Information should be consulted for detailed prescribing information.

Exclusion Criteria

If ANY of the following are selected, the patient will NOT meet criteria for vedolizumab.

- ☐ Untreated latent or active tuberculosis infection
- ☐ Uncontrolled, active, severe infection (however, vedolizumab may be started/restarted once treatment for the infection is initiated).
- ☐ Hepatitis B surface antigen (HBsAg)-positive and not on antiviral prophylaxis. Vedolizumab may be initiated after starting antiviral prophylaxis.
- ☐ Untreated HIV infection. Treated, well-controlled, asymptomatic HIV-positive patients can be treated with vedolizumab.
- ☐ Congenital or acquired immunodeficiency
- ☐ Concomitant live or live-attenuated vaccines or administration of inactivated, live, or live-attenuated vaccines less than 2 weeks before initiation of vedolizumab^1
- ☐ Concomitant treatment with drugs that have a contraindicated drug interaction (e.g., Bacillus Calmette-Guerin [BCG] vaccine) unless risk-benefits favor use
- ☐ Primary nonresponse to natalizumab

Inclusion Criteria

ALL of the following must be selected in order to meet criteria:

- ☐ Prescribed and monitored by a VA/VA Community Care gastroenterologist or locally designated expert.
- ☐ Completed tuberculosis (TB) test using tuberculin skin test or interferon-gamma release assay [IGRA].^2

- ☐ Completed hepatitis B screening (HBsAg, total antibody to hepatitis B core antigen [anti-HBc] and antibody to hepatitis B surface antigen [anti-HBs]).^3
- ☐ Current or past completion of hepatitis C screening. (Vedolizumab may be initiated while waiting for test results.)^4

Additional Inclusion Criteria

ONE of the following must be selected in order to meet criteria:

- ☐ Current or prior overall physician assessment of "moderate to severe" CD or UC confirmed by endoscopy or imaging, and TNFI is medically inadvisable.^5
- ☐ Current or prior overall physician assessment of "moderate to severe" CD or UC, and primary nonresponse, inadequate partial response, or loss of response^6 after 12 weeks of **one TNFI** in the presence of **adequate TNFI levels** (mechanistic failure).
- ☐ Current or prior overall physician assessment of "moderate to severe" CD and loss of response^6 to **infliximab/biosimilar and another TNFI** despite therapeutic drug monitoring (TDM)-based optimized dosing to address pharmacokinetic failure.^7
- ☐ Current or prior overall physician assessment of "moderate to severe" UC and loss of response^6 to a **TNFI** (**infliximab/biosimilar preferred)** despite therapeutic drug monitoring (TDM)-based optimized dosing to address pharmacokinetic failure.^7
- ☐ No prior TNFI was deemed required because of documented current or prior overall physician assessment of "moderate" CD or UC disease or documented absence of extraintestinal manifestations.
- ☐ Underwent IPAA and has documented chronic antibiotic-refractory or -dependent CD or UC pouchitis^8 with intolerance, loss of response, or medical inadvisability to long-term antibiotic therapy. No prior TNFI required.
- ☐ Maintenance of clinical response or remission achieved with cyclosporine rescue therapy when immunomodulator maintenance is medically inadvisable (used for acute, severe UC).
- ☐ Prevention of recurrence after surgery for CD if TNFI therapy is medically inadvisable.

Abbreviations: IPAA, ileal-pouch anal anastomosis

See footnote 9 for sequencing drugs.

Additional Inclusion Criteria

Select if applicable:

- ☐ If HBsAg-negative but anti-HBc-positive: A GI/liver or infectious diseases expert has been consulted for advice on whether to start antiviral prophylaxis or to preemptively monitor for HBV reactivation.^10
- ☐ For females who can become pregnant: Counseling provided on potential risks vs benefits of treatment and the use of effective contraception.

Footnotes

1 When possible, vaccinations should be updated before the patient initiates vedolizumab. Unless contraindicated, recombinant zoster (SHINGRIX) vaccine should be completed or at least initiated by the end of the first year of treatment with vedolizumab, preferably when dosage is low, disease is stable, or at other times when a robust immune response to vaccination can be expected.

2 Routine retesting for TB is not required for prescription renewals. Retesting in high-risk patients should be considered.

3 Routine retesting for hepatitis B virus is not required for prescription renewals. Retesting in high-risk patients should be considered. Anti-HBs may help to identify patients who require initial or booster vaccination (anti-HBs titers >= 10 IU/L are generally considered protective) or HBsAg-negative patients without past vaccination who have occult HBV from past infection (anti-HBs positive and lost anti-HBc).

4 Routine retesting for hepatitis C virus is not required for prescription renewals. Retesting in high-risk patients should be considered.

5 Infliximab/biosimilar and adalimumab/biosimilar are the preferred TNFIs in CD. Another option for CD is certolizumab. Infliximab/biosimilar is preferred in UC. Other options for UC in TNFI-naïve patients are adalimumab and golimumab. Adalimumab is less preferred than vedolizumab and tofacitinib in TNFI-exposed UC patients.

6 Loss of response refers to active disease confirmed by endoscopy or imaging

7 Pharmacokinetic failure resulting in low TNFI levels may be immune-mediated or non–immune-mediated.
If **TNFI levels are undetectable with high antidrug antibody (AdAb) titers** (i.e., immune-mediated pharmacokinetic failure): Consider adding an immunomodulator. In CD, a switch from infliximab/biosimilar to a second TNFI is preferred over a switch to another drug class (such as vedolizumab, risankizumab-rzaa, or upadacitinib). Infliximab/biosimilar and adalimumab/biosimilar are the preferred TNFIs in CD. In UC, if the patient is on adalimumab, a switch to a second TNFI is preferred over a switch to another drug class. if on infliximab, switch to a non-TNFI (one of vedolizumab, tofacitinib, upadacitinib, etrasimod, ozanimod, or risankizumab-rzaa). Infliximab/biosimilar is the preferred TNFI. A trial of just one TNFI may be sufficient (prefer not switching infliximab to adalimumab, which has lower efficacy in UC).
If **TNFI levels are undetectable with low AdAb titers** (i.e., also immune-mediated pharmacokinetic failure), optimize dosing (i.e., shorten dosing interval, increase dose, or both; add a conventional immunomodulator if not already started).
If **trough TNFI levels are subtherapeutic with low or high AdAb titers**, optimal management is uncertain.
If **TNFI trough levels are subtherapeutic with no AdAbs** (i.e., non–immune-mediated pharmacokinetic failure due to rapid drug clearance), shorten the TNFI dosing intervals, increase the dose, or both.

8 The American Gastroenterological Association (AGA) guidelines on pouchitis and inflammatory pouchitis disorders [Barnes, et al. Gastroenterology. 2024;166(1):59–85] defines **chronic antibiotic-refractory pouchitis** as relapsing-remitting or continuous symptoms of pouchitis with inadequate response to typical antibiotic therapy (ongoing symptoms attributable to pouchitis), often needing escalation to other therapies. The AGA defines **chronic antibiotic-dependent pouchitis** as recurrent episodes of pouchitis that respond to antibiotic therapy but relapse shortly after stopping antibiotics (typically within days to weeks), and often require recurrent or continuous antibiotic therapy or other advanced therapies to achieve symptom control.

9 **Sequencing CD Drugs (1L = First-line, 2L = Second-line, etc.)**

1L: Infliximab/biosimilar or adalimumab/biosimilar. Vedolizumab may be used 1L for "moderate" CD, absence of extraintestinal manifestations, or pouchitis as per criteria.

2L/3L: Vedolizumab, upadacitinib, or risankizumab-rzaa (one drug should be risankizumab-rzaa as 2L or 3L drug)

4L: Mirikizumab-mrkz, guselkumab, or ustekinumab/biosimilar

Sequencing UC Drugs

1L: Infliximab/biosimilar (preferred) or adalimumab/biosimilar (less effective alternative). Vedolizumab may be used 1L for "moderate" UC, absence of extraintestinal manifestations, or pouchitis as per criteria.

2L/3L: Vedolizumab, tofacitinib, upadacitinib, etrasimod, ozanimod, or risankizumab-rzaa (one drug should be risankizumab-rzaa as 2L or 3L drug)

4L: Mirikizumab-mrkz, guselkumab, or ustekinumab/biosimilar

10 In patients who are HBsAg-negative but anti-HBc-positive, the presence of antibody to hepatitis B surface antigen (anti-HBs) does not guarantee protection against HBV reactivation, and the available evidence is insufficient to support the use of anti-HBs titers in deciding whether to give antiviral prophylaxis. References: Reddy K, et al. American Gastroenterological Association Institute Guideline on the Prevention and Treatment of Hepatitis B Virus Reactivation During Immunosuppressive Drug Therapy. Gastroenterology. 2015;148(1):215–219. DOI:https://doi.org/10.1053/j.gastro.2014.10.039. Ekpanyapong S, Reddy KR. Hepatitis B Virus Reactivation: What Is the Issue, and How Should It Be Managed? Clin Liver Dis. 2020 Aug;24(3):317-333. doi: 10.1016/j.cld.2020.04.002.]

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