Applicable Drugs: Veppanu (vepdegestrant)

Preferred: N/A

Non-preferred: N/A

Date of Origin: 8/31/2026

Date Last Reviewed / Revised: N/A

PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I to V are met.)

I. Documentation of one of the following FDA-approved diagnosis AND must meet all criteria listed under the applicable diagnosis:

FDA-Approved Indication(s)

A. Breast Cancer

i. Documentation of advanced or metastatic disease

ii. Documentation of estrogen receptor (ER) positive, human epidermal growth factor receptor 2 (HER2) negative, and estrogen receptor-1 (ESR1)-mutated disease

iii. Documentation of disease progression following at least one line of endocrine therapy (ex: anastrozole, exemestane, fulvestrant, letrozole, tamoxifen, etc.) and at least one cyclin-dependent kinase 4/6 inhibitor (CDK4/6) (ex: Ibrance [palbociclib], Kisqali [ribociclib], or Verzenio [abemaciclib]) in the metastatic setting

iv. Veppanu will be used as a single agent

II. Minimum age requirement: 18 years old

III. Treatment must be prescribed by or in consultation with an oncologist or hematologist.

IV. Request is for a medication with the appropriate FDA labeling, or its use is supported by current National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1 or 2A.

V. Refer to the plan document for the list of preferred products. If the requested agent is not listed as a preferred product, must have documented treatment failure or contraindication to the preferred product(s).

EXCLUSION CRITERIA

- N/A

OTHER CRITERIA

- Pre/peri-menopausal women and men should be treated with a gonadotropin-releasing hormone agonist (GnRH) (e.g., Zoladex [goserelin], Lupron [leuprolide], etc.).

QUANTITY / DAYS SUPPLY RESTRICTIONS

- Limited to 30 tablets per 30-day supply

APPROVAL LENGTH

- **Authorization:** 6 months
- **Re-Authorization:** 6 months. An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and does not show evidence of progressive disease.

APPENDIX

N/A

REFERENCES

1. Veppanu. Prescribing Information. Pfizer, Inc. 2026. Accessed June 22, 2026. www.accessdata.fda.gov/drugsatfda_docs/label/2026/219835Orig1s000lbl.pdf
2. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. Breast Cancer. Version 5.2026. Updated July 7, 2026. Accessed July 20, 2026.

DISCLAIMER: Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgement in providing the most appropriate care for their patients.