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.