This Coverage Policy applies to Individual Health Insurance Marketplace benefit plans only.

**Erivedge® (vismodegib)**

**COVERAGE POLICY**

Erivedge is covered for members who meet the following criteria:

A. For the treatment of adults with metastatic basal cell carcinoma, or with locally advanced basal cell carcinoma that has recurred following surgery or who are not candidates for surgery, and who are not candidates for radiation.

**AUTHORIZATION PERIOD AND LIMITATIONS**

**Initial Approval:** 6 months

**Extended Approval:** 1 year, if benefit is demonstrated by control of tumor growth: No evidence of increase in tumor size relative to pre-treatment report as shown by radiologic study or direct evaluation

**Quantity limit:** 1 tablet/day

**NON-COVERAGE**

Erivedge is NOT covered for members with the following criteria:

A. Use not approved by the FDA; and

B. The use is unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining ‘accepted use’)

C. Use in pregnancy (Black Box Warning of embryo-fetal death and severe birth defects)

**REFERENCES**


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