Prior Authorization Guideline

Guideline Name	Veppanu

Guideline Note:

Effective Date:	10/1/2026

1 . Criteria

Product Name: Veppanu 100 mg tablet, Veppanu 200 mg tablet	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Requested drug is FDA-approved for the condition being treated

OR

1.2 Treatment is supported for the diagnosis in the NCCN guidelines

AND

2 - Prescribed by one of the following:

2.1 Hematologist

OR

2.2 Oncologist

AND

3 - Medical record documentation of an estrogen receptor 1 (ESR1) mutation

AND

4 - Medical record documentation of intolerance, clinical failure, or contraindication to one of the following:

4.1 Orserdu

OR

4.2 Inluriyo

Product Name: Veppanu 100 mg tablet, Veppanu 200 mg tablet	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy