pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ZEPOSIA (ozanimod) PRIOR AUTHORIZATION FORM

(form effective 1/3/2022)

Prior authorization guidelines for **Zeposia** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	total pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	MA Provider ID#:
LTC facility contact/phone:		Street address:	
Beneficiary Name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested *(check all products being requested)*:	☐Zeposia 7-Day Starter Pack [(4) 0.23 mg capsules and (3) 0.46 mg capsules] --- Quantity: 1 pack for 7 days ☐Zeposia Starter Kit [(4) 0.23 mg capsules, (3) 0.46 mg capsules, and (30) 0.92 mg capsules) --- Quantity: 1 pack for 37 days ☐Zeposia capsule Strength: _____ mg Quantity: _____ Refills: _____ ☐Zeposia _____ Quantity: _____ Refills: _____
Directions:	☐0.23 mg QD days 1 through 4, then 0.46 mg QD days 5 through 7, then 0.92 mg QD thereafter ☐0.92 mg QD ☐other: _____

Diagnosis *(submit documentation)*:	Dx code *(required)*:
Is the beneficiary currently being treated with Zeposia?	☐Yes ☐No *Submit documentation.*
Is Zeposia being prescribed by or in consultation with a neurologist or gastroenterologist?	☐Yes ☐No *Submit documentation of consultation if applicable.*

Check all of the following that apply to the beneficiary and SUBMIT DOCUMENTATION for each item.

☐Has severe untreated sleep apnea
☐Will be taking a monoamine oxidase inhibitor while taking Zeposia (e.g., selegiline, phenelzine)
☐Has a comorbid heart condition – describe: _____
☐Experienced any of the following in the past 6 months:
- ☐Myocardial infarction
- ☐Unstable angina
- ☐Stroke
- ☐Transient ischemic attack
- ☐Decompensated heart failure
- ☐Class III/IV heart failure

INITIAL requests

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐**Is being treated for MULTIPLE SCLEROSIS (MS):**
- ☐Has a relapsing form of MS

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☐ Tried and failed or has a contraindication or an intolerance to the preferred Multiple Sclerosis Agents that are FDA-approved or medically accepted for the treatment of MS. *Refer to https://papdl.com/preferred-drug-list for a list of preferred Multiple Sclerosis Agents.*

☐ **Is being treated for ULCERATIVE COLITIS (UC):**

- ☐ Has moderate-to-severe disease
- ☐ Has disease that is associated with high-risk or poor prognostic features
- ☐ Failed to achieve remission with an induction course of corticosteroids
- ☐ Has a contraindication or intolerance to an induction course of corticosteroids
- ☐ Failed to maintain remission with an immunomodulator (e.g., AZA, cyclosporine, 6-MP, MTX)
- ☐ Has a contraindication or intolerance to immunomodulators (e.g., AZA, cyclosporine, 6-MP, MTX)
- ☐ Tried and failed or has a contraindication or intolerance to the preferred Cytokine and CAM Antagonists that are FDA-approved or medically accepted for the treatment of UC. *Refer to https://papdl.com/preferred-drug-list for a list of preferred Cytokine and CAM Antagonists.*

RENEWAL requests

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐ For a diagnosis of MULTIPLE SCLEROSIS, experienced improvement or stabilization of the MS disease course since starting Zeposia
☐ For a diagnosis of ULCERATIVE COLITIS, experienced improvement in disease activity or level of functioning since starting Zeposia

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: