SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Velsipity® (etrasimod)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Quantity Limit: 1 tablet per day

NOTE: The Health Plan considers the use of concomitant therapy with more than one biologic immunomodulator (e.g., Dupixent, Entyvio, Humira, Rinvoq, Stelara) prescribed for the same or different indications to be experimental and investigational. Safety and efficacy of these combinations has **NOT** been established and will **NOT** be permitted.

- ❑ Will the member be discontinuing a previously prescribed biologic if approved for requested medication?
  ❑ Yes **OR** ❑ No
- ❑ If yes, please list the medication that will be discontinued and the medication that will be initiated upon approval along with the corresponding effective date.
  Medication to be discontinued: _____ **Effective date:** _____
  Medication to be initiated: _____ **Effective date:** _____

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member has a diagnosis of moderate-to-severe active **ulcerative colitis**
- ❑ Medication has been prescribed by a **Gastroenterologist**
- ❑ Member meets **ONE** of the following unless member has a contraindication or intolerance:
  - ❑ Member has tried and failed corticosteroids
  - ❑ Member has tried and failed at least **ONE** of the following **DMARD**:
    - ❑ 5-aminosalicylates (balsalazide, olsalazine, sulfasalazine)
    - ❑ oral mesalamine (Apriso, Asacol/HD, Delzicol, Lialda, Pentasa)
    - ❑ Other immunosuppressant drug: _____
  - ❑ Member has previously tried and failed another biologic medication other than the requested medication (e.g., Skyrizi, Tremfya, ustekinumab)
- ❑ Member meets **ONE** of the following:
  - ❑ Member meets **BOTH** of the following:
    - ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** of the **PREFERRED** biologics below **(verified by chart notes or pharmacy paid claims)**:

❑ Preferred adalimumab product	❑ Rinvoq®	❑ Skyrizi®
❑ Simponi®	❑ generic tofacitinib/ER	❑ Tremfya®
❑ Preferred ustekinumab product	❑ Zymfentra™	

    - ❑ Member tried and failed, has a contraindication, or intolerance to Zeposia®
  - ❑ Member has been established on Velsipity® for at least 90 days **AND** claims history indicates **at least a 90-day supply of Velsipity was dispensed within the past 130 days (verified by chart notes or pharmacy paid claims)**

Medication being provided by Specialty Pharmacy – Proprium Rx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

***Approved by Pharmacy and Therapeutics Committee:** ~~1/18/2024; 11/21/2024;~~ **3/26/2026**
REVISED/UPDATED/REFORMATTED: ~~2/9/2024; 8/12/2024; 12/16/2024; 7/7/2025. 12/22/2025;~~ **8/5/2026**