

SENTARA COMMUNITY PLAN (MEDICAID)

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: Zeposia® (ozanimod) - Ulcerative Colitis Indication

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: _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight: _____ Date: _____

Recommended Dosage: Oral: Initial: 0.23 mg once daily on days 1 through 4; then 0.46 mg once daily on days 5 through 7; maintenance dose: 0.92 mg once daily starting on day 8

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 **ulcerative colitis**
- Medication has been prescribed by a **Gastroenterologist**

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- Member has moderate to severe active disease with inadequate response after a **90-day** trial of **ONE** of the following conventional therapies (**verified by chart notes or pharmacy paid claims**):
 - 6-mercaptopurine
 - aminosalicylates (e.g., mesalamine, balsalazide, olsalazine)
 - sulfasalazine
 - azathioprine
 - corticosteroids (e.g., budesonide, high dose steroids: 40-60 mg of prednisone daily)
- Member meets **ONE** of the following:
 - Member tried and failed, has a contraindication, or intolerance to **BOTH** of the following **PREFERRED** biologics:
 - Humira[®]
 - Infliximab
 - Member has been established on Zeposia[®] for at least 90 days **AND** prescription claims history indicates **at least a 90-day supply of Zeposia was dispensed within the past 130 days** (**verified by chart notes or pharmacy paid claims**)

Medication being provided by a Specialty Pharmacy - PropriumRx

*****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.****