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: Zeposia® (ozanimod)

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 capsule per day

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

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:** _____

(Continued on next page)

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:
  - ❑ Member has tried and failed budesonide or high dose steroids (40-60 mg prednisone)
  - ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
    - ❑ 5-aminosalicylates (balsalazide, olsalazine, sulfasalazine)
    - ❑ oral mesalamine (Apriso, Asacol/HD, Delzicol, Lialda, Pentasa)
- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** of the following **PREFERRED** biologics:
    - ❑ **ONE** preferred adalimumab product
    - ❑ Skyrizi® SC (on-body injector)
    - ❑ Stelara®
    - ❑ Tremfya®
    - ❑ Zymfentra™
  - ❑ 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 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:** ~~9/16/2021; 3/17/2022; 2/16/2023; 8/17/2023;~~ **11/21/2024**
REVISED/UPDATED/REFORMATTED: ~~10/29/2021; 11/1/2021; 6/16/2022; 12/21/2022; 1/31/2023; 8/13/2023; 10/6/2023; 3/27/2024; 8/12/2024; 12/16/2024;~~ **7/7/2025**