HIGHMARK HEALTH OPTIONS

Updated: 06/2022
DMMA Approved: 08/2022

Request for Prior Authorization for Zeposia (ozanimod)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for **Zeposia (ozanimod)** require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Zeposia (ozanimod) Prior Authorization Criteria:

For all requests for Zeposia (ozanimod) all of the following criteria must be met:

- The drug is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
- Must be prescribed by, or in consultation with, a neurologist or a physician that specializes in the treatment of MS
- The drug will not be given in combination with other disease modifying therapies approved for the treatment of MS
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- If the request is for a non-preferred medication, must provide documentation showing one of the following:
    - The member has tried and failed (which will be verified via pharmacy claims if available) or had an intolerance to two or more preferred agents
    - All of the preferred agents would be contraindicated.

Coverage may be provided with a diagnosis of relapsing forms of multiple sclerosis (e.g. relapsing-remitting, secondary-progressive, or clinically isolated syndrome) and the following criteria is met:

- For members initiating therapy for the first time, must provide documentation of one of the following:
    - One clinical relapse (e.g. functional disability, hospitalization, acute steroid therapy, etc.) during the prior year
    - Two relapses within the prior two years
    - A single clinical demyelinating event and 2 or more brain lesions characteristic of MS
- Member must have documented Expanded Disability Status Scale (EDSS) score of 6.5 or lower
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
    - Must include documentation of one of the following:
        - No increase in their Expanded Disability Status Scale (EDSS) score
        - Member did not experience 1 or more relapses
        - Member does not have 2 or more unequivocally new MRI-detected lesions
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided with a diagnosis of moderate to severe ulcerative colitis and the following criteria is met:

- Must meet one of the following:
  - Will also be used for concomitant multiple sclerosis
  - Have documentation of trial and failure, contraindication or intolerance to an immunomodulator (i.e., Azathioprine, 6-Mercaptopurine, Methotrexate)
- **Initial Duration of Approval**: 6 months
- **Reauthorization Criteria:**
  - Must provide documentation of a positive clinical response
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

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ZEPOSIA (OZANIMOD)
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon-Fri 8:00am to 7:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No		

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: ☐ Relapsing Multiple Sclerosis ☐ Primary-Progressive Multiple Sclerosis ☐ Other: _____
ICD-10 Code: _____

What is the member's *current* Expanded Disability Status Scale (EDSS) score? _____ Date of assessment: _____

Please provide a medication list of any concurrent medications that the member will be taking in the table below.

For Relapsing Multiple Sclerosis:
Check any of the applicable statements:
☐ Member had at least one clinical relapse (e.g. functional disability, hospitalization, acute steroid therapy, etc.) during the prior year
☐ Member had two relapses within the prior two years
☐ Member had a single clinical demyelinating event and 2 or more brain lesions characteristic of MS

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

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ZEPOSIA (OZANIMOD)
PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2

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MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

MEDICAL HISTORY (Complete for ALL requests)

For Ulcerative Colitis:
Check any of the applicable statements:
☐ Member has moderately to severely active disease
☐ Zeposia will also be used for concomitant multiple sclerosis
☐ Member has documentation of trial and failure, contraindication or intolerance to an immunomodulator (i.e., Azathioprine, 6-Mercaptopurine, Methotrexate)

SUPPORTING INFORMATION or CLINICAL RATIONALE

REAUTHORIZATION

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No
Please describe:_____

For Relapsing Multiple Sclerosis:
What was the member's *initial* Expanded Disability Status Scale (EDSS) score? _____ Date of Assessment: _____
How many relapses has the member had in the last year? _____
How many unequivocally new MRI-detected lesions has the member had in the last year? _____

Prescribing Provider Signature	Date