Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Zeposia

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this request for continuation of therapy with Zeposia (ozanimod)?

☐ Yes ☐ No

Q2. Is prescribed Zeposia (ozanimod) for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication?

☐ Yes ☐ No

Q3. Is prescribed Zeposia (ozanimod) by or in consultation with an appropriate specialist (i.e., a neurologist for a diagnosis of multiple sclerosis or a gastroenterologist for a diagnosis of ulcerative colitis)?

☐ Yes ☐ No

Q4. Does the patient have a contraindication to Zeposia (ozanimod)?

☐ Yes ☐ No

Q5. Does the patient have a diagnosis of multiple sclerosis?

☐ Yes ☐ No

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Q6. Does the patient have a history of therapeutic failure of or a contraindication or an intolerance to the preferred Multiple Sclerosis Agents approved for the beneficiary's diagnosis (such as Aubagio, Avonex, Betaseron, Dalfampridine ER Tablet, Dimethyl Fumarate, Gilenya, Glatiramer, Glatopa, Rebif, Rebif Rebidose, Tysabri)?

☐ Yes ☐ No

Q7. Does the patient have a current history (within the past 90 days) of being prescribed Zeposia (ozanimod)?

☐ Yes ☐ No

Q8. Does the patient have a diagnosis of ulcerative colitis (UC)?

☐ Yes ☐ No

Q9. Does the patient have a diagnosis of mild UC that is associated with multiple poor prognostic factors OR moderate to severe UC?

☐ Yes ☐ No

Q10. Has the patient 1) Failed to achieve remission with or has a contraindication or an intolerance to an induction course of corticosteroids; 2) Failed to maintain remission with an immunomodulator in accordance with current consensus guidelines (e.g., American College of Gastroenterology, American Gastroenterological Association, European Crohn's and Colitis Organization, etc.) OR has a contraindication or an intolerance to immunomodulators in accordance with current consensus guidelines OR 3) Has achieved remission with Zeposia (ozanimod) AND will be using Zeposia (ozanimod) as maintenance therapy to maintain remission?

☐ Yes ☐ No

Q11. Does the patient have a history of therapeutic failure of or a contraindication or an intolerance to the preferred Cytokine and CAM Antagonists approved or medically accepted for treatment of UC or has a current history (within the past 90 days) of being prescribed Zeposia (ozanimod)?

☐ Yes ☐ No

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Q12. Is prescribed a dose that is consistent with the FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature and is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed literature?

☐ Yes ☐ No

Q13. Is the patient prescribed Zeposia (ozanimod) by or in consultation with an appropriate specialist (i.e., a neurologist for a diagnosis of multiple sclerosis or a gastroenterologist for a diagnosis of ulcerative colitis)?

☐ Yes ☐ No

Q14. Is the patient prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q15. Does the patient have a contraindication to Zeposia (ozanimod)?

☐ Yes ☐ No

Q16. Does the patient have a diagnosis of multiple sclerosis?

☐ Yes ☐ No

Q17. Does the patient have documented improvement or stabilization of the multiple sclerosis disease course?

☐ Yes ☐ No

Q18. Does the patient have a diagnosis of UC?

☐ Yes ☐ No

Q19. Has the patient experienced improvement in disease activity and/or level of functioning since starting Zeposia (ozanimod)?

☐ Yes ☐ No

Q20. Additional Information:

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Member Name:	Prescriber Name:

Prescriber Signature _____ Date _____

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