

FAX FORM AND CLINICAL DOCUMENTATION

ULCERATIVE COLITIS AGENTS PRIOR AUTHORIZATION FORM (form effective 1/8/2024)

Prior authorization guidelines for **Ulcerative Colitis Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <u>https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx</u>.

New request Renewal reques	t total pages:	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Dosage form:	Strength:	
Directions:		Quantity:	Refills:
Diagnosis (<u>submit documentation</u>):		Dx code (<u>required</u>):	
Is the beneficiary currently being treated with the requested medication?	Yes – date of last dose:	Submi	t documentation.

Complete all sections that apply to the beneficiary and this request. Check all that apply and <u>submit documentation</u> for each item.

	INITIAL requests
1.	For a SPHINGOSINE 1-PHOSPHATE RECEPTOR (S1PR) MODULATOR (eg, VELSIPITY [etrasimod], ZEPOSIA [ozanimod]) for
	treatment of ulcerative colitis (UC):
	Is prescribed the medication by or in consultation with an appropriate specialist (eg, a gastroenterologist)
	Has moderate-to-severe UC
	Has UC associated with multiple poor prognostic factors
	Tried and failed to achieve remission with or has a contraindication or an intolerance to an induction course of corticosteroids
	Tried and failed to maintain remission with or has a contraindication or an intolerance to conventional immunomodulators (eg, AZA,
	cyclosporine, 6-MP, MTX)
	Has achieved remission with the requested medication AND:
	Will be using the requested medication as maintenance therapy to maintain remission

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		plerance to the preferred Cytokine and CAM Antagonists that are FDA-approved or to <u>https://papdl.com/preferred-drug-list</u> for a list of preferred Cytokine and CAM
	Antagonists.)	to <u>mups.//papul.com/preferred-drug-list</u> for a list of preferred Cytokine and CAM
	Request is for VELSIPITY (etrasimod) AND:	
	Has a comorbid heart condition – describe:	
	Experienced any of the following in the past 6	months:
		Transient ischemic attack
		Decompensated heart failure requiring hospitalization
	Stroke	Class III or IV heart failure
	Request is for ZEPOSIA (ozanimod) AND:	
	Has severe untreated sleep apnea	
		hibitor while taking Zeposia (e.g., selegiline, phenelzine)
	Has a comorbid heart condition – describe:	
	Experienced any of the following in the past 6	
	Myocardial infarction	Transient ischemic attack
	Unstable angina	Decompensated heart failure requiring hospitalization
	Stroke	Class III or IV heart failure
2.	For all other NON-PREFERRED Ulcerative Colitis	Agonte
Ζ.		Service a service of the preferred Ulcerative Colitis Agents approved or medically accepted
		· · · · · · · · · ·
	• • • •	<u>dl.com/preferred-drug-list</u> for a list of preferred and non-preferred drugs in this
	class.)	
		RENEWAL requests
1.	For a SPHINGOSINE 1-PHOSPHATE RECEPTOR	S1PR) MODULATOR (eg, VELSIPITY [etrasimod], ZEPOSIA [ozanimod]):
	-	
	Is prescribed the medication by or in consultation v	
	·	vith an appropriate specialist (eg, a gastroenterologist)
	Experienced improvement in disease activity or lev	
	Experienced improvement in disease activity or leven activity or leven activity or leven activity of the second se	vith an appropriate specialist (eg, a gastroenterologist) vel of functioning since starting the requested medication
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	Experienced improvement in disease activity or leven activity or leven activity or leven activity or leven activity of the second secon	vith an appropriate specialist (eg, a gastroenterologist) vel of functioning since starting the requested medication months:
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	 Experienced improvement in disease activity or leven activity or leven activity of the second second	vith an appropriate specialist (eg, a gastroenterologist) vel of functioning since starting the requested medication months: Transient ischemic attack Decompensated heart failure requiring hospitalization
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	 Experienced improvement in disease activity or leven in the service of the service	vith an appropriate specialist (eg, a gastroenterologist) vel of functioning since starting the requested medication months: Transient ischemic attack Decompensated heart failure requiring hospitalization Class III or IV heart failure
	 Experienced improvement in disease activity or levent is for VELSIPITY (etrasimod) AND: Has a comorbid heart condition – describe: Experienced any of the following in the past 6 Myocardial infarction Unstable angina Stroke Request is for ZEPOSIA (ozanimod) AND: Has severe untreated sleep apnea Will be taking a monoamine oxidase inhibitor 	<pre>vith an appropriate specialist (eg, a gastroenterologist) vel of functioning since starting the requested medication months:</pre>
	 Experienced improvement in disease activity or levent is for VELSIPITY (etrasimod) AND: Has a comorbid heart condition – describe: Experienced any of the following in the past 6 Myocardial infarction Unstable angina Stroke Request is for ZEPOSIA (ozanimod) AND: Has severe untreated sleep apnea Will be taking a monoamine oxidase inhibitor for the severe under the severe unde	<pre>vith an appropriate specialist (eg, a gastroenterologist) vel of functioning since starting the requested medication months:</pre>
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	 Experienced improvement in disease activity or level Request is for VELSIPITY (etrasimod) AND: Has a comorbid heart condition – describe: Experienced any of the following in the past 6 Myocardial infarction Unstable angina Stroke Request is for ZEPOSIA (ozanimod) AND: Has severe untreated sleep apnea Will be taking a monoamine oxidase inhibitor Has a comorbid heart condition – describe: Experienced any of the following in the past 6 Myocardial infarction Unstable angina Stroke 	<pre>vith an appropriate specialist (eg, a gastroenterologist) vel of functioning since starting the requested medication months:</pre>
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