Zeposia (ozanimod)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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Revision Date: 8/15/2024

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Clinically Isolated Syndrome (CIS) ☐ Relapsing Remitting Multiple Sclerosis (RRMS) ☐ Secondary Progressive Multiple Sclerosis (SPMS) ☐ Ulcerative Colitis (UC) ☐ Other diagnosis: _____ICD-10:_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Is drug going to be used in conjunction with a clinical trial? ☐ Yes ☐ No

<u>Initial Request for Multiple Sclerosis</u>:

Is the prescriber a neurologist? ☐ Yes ☐ No

Has patient had a 3 month trial each of at least 2 of the following? ☐ Yes ☐ No *Please provide documentation.*
☐dimethyl fumarate
☐ fingolimod
☐ glatiramer acetate
☐ teriflunomide

<u>Initial Request for Ulcerative Colitis</u>:

Is the prescriber a gastroenterologist? ☐ Yes ☐ No

Does patient have Crohn's disease or indeterminate colitis? ☐ Yes ☐ No *Please provide documentation.*

Has patient tried and failed at least one of the following three therapies: corticosteroids, azathioprine and/or 6-mercaptopurine? ☐ Yes ☐ No *Please submit chart documentation.*

Has patient tried and failed at least three months of the biosimilar Humira-adalimumab-aacf? ☐ Yes ☐ No *Please submit chart documentation.*

Will patient use requested medication in combination with another biologic response modifier or immunomodulatory agent? ☐ Yes ☐ No

<u>Renewal Request:</u>

Is prescriber a neurologist? ☐ Yes ☐ No

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Is prescriber a gastroenterologist? □ **Yes** □ **No**

Is patient continuing to have a positive response to therapy? □ **Yes** □ **No** ***Please submit chart documentation.***

Will patient use requested medication in combination with another biologic response modifier or immunomodulatory agent? □ **Yes** □ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

***Please note:** Not all drugs/diagnoses are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Revision Date: 8/15/2024

Prime THERAPEUTICS™