

# ZEPOSIA

## PRIOR AUTHORIZATION REQUEST

### PRESCRIBER FAX FORM

**Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.**

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit [www.myprime.com](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermymeds.com](http://covermymeds.com) to begin using this free service.

**What is the priority level of this request?**

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

**Today’s Date:** \_\_\_\_\_

**PATIENT AND INSURANCE INFORMATION**

**Date of Service (if differs from Today’s Date):** \_\_\_\_\_

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

**PRESCRIBER/CLINIC INFORMATION**

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

Patient diagnosis: <input type="checkbox"/> Moderately to severely active ulcerative colitis (UC) <input type="checkbox"/> A relapsing form of multiple sclerosis (MS) <input type="checkbox"/> Other (ICD code and description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<p><b>For all requests:</b></p> <p>1. Is the patient currently being treated with the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No          If yes, is the patient currently stable on the requested agent? <b>Please note, chart notes are required.</b>..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Has the patient been treated with the requested agent within the past 90 days?..... <input type="checkbox"/> Yes <input type="checkbox"/> No          If yes, is the patient at risk if therapy is changed?..... <input type="checkbox"/> Yes <input type="checkbox"/> No          If yes, please specify risk: _____</p> <p>3. Has the patient received the starter pack through any means (e.g., manufacturer supplied) and the patient is requesting for initial maintenance dose? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Does the patient have any FDA labeled contraindications to the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No          If yes, please specify FDA labeled contraindications: _____</p> <p>5. Is the prescriber a specialist in the area of the patient’s diagnosis (e.g., neurologist for the diagnosis of multiple sclerosis, gastroenterologist for the diagnosis of ulcerative colitis), or has the prescriber has consulted with a specialist in the area of the patient’s diagnosis?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Is the patient’s age within FDA labeling for the requested indication for the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No          If no, please provide support for using the requested agent for the patient’s age for the requested indication: _____</p>	
<p><b>Please continue to the next page.</b></p>	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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**For all requests (continued):**

7. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** \_\_\_\_\_

**For a relapsing form of multiple sclerosis (MS) requests:**

8. Will the patient be using the requested agent in combination with another disease modifying therapy (DMT) [Aubagio (teriflunomide), Avonex (interferon b-1a), Bafiertam (monomethyl fumarate), Betaseron (interferon b-1b), Briumvi (ublituximab-xiyy), Copaxone (glatiramer), dimethyl fumarate, Extavia (interferon b-1b), fingolimod, Gilenya (fingolimod), Glatopa (glatiramer), glatiramer, Kesimpta (ofatumumab), Lemtrada (alemtuzumab), Mavenclad (cladribine), Mayzent (siponimod), Ocrevus (ocrelizumab), Ocrevus Zunovo (ocrelizumab-hyaluronidase), Plegridy (peginterferon b-1a), Ponvory (ponesimod), Rebif (interferon b-1a), Tascenro ODT (fingolimod), Tecfidera (dimethyl fumarate), teriflunomide, Tysabri (natalizumab), Vumerity (diroximel fumarate), Zeposia (ozanimod)]? .....  Yes  No  
 If yes, will the patient be using the requested agent sequentially with Mavenclad (cladribine) (e.g., relapse between cycles of Mavenclad)? .....  Yes  No

**For ulcerative colitis (UC) requests:**

9. Does the patient have severely active ulcerative colitis? .....  Yes  No  
 10. Does the patient's medication history indicate use of another biologic immunomodulator agent that is FDA labeled or supported in compendia (AHFS, or DrugDex 1, 2a, or 2b level of evidence) for the treatment of UC?  Yes  No  
 If yes, please specify: \_\_\_\_\_  
 11. Has the patient tried and had an inadequate response to ONE conventional agent (i.e., 6-mercaptopurine, azathioprine, balsalazide, corticosteroids, cyclosporine, mesalamine, sulfasalazine) used in the treatment of UC after at least a 3-month duration of therapy? .....  Yes  No  
 If yes, please specify: \_\_\_\_\_  
 If no, does the patient have an intolerance or hypersensitivity to ONE of the conventional agents used in the treatment of UC? .....  Yes  No  
 If yes, please explain intolerance/hypersensitivity: \_\_\_\_\_  
 If no, does the patient have an FDA labeled contraindication to ALL of the conventional agents used in the treatment of UC? .....  Yes  No  
 If yes, please specify FDA labeled contraindication: \_\_\_\_\_

12. Will the patient be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) Abrilada (adalimumab-afzb), Actemra (tocilizumab), Adalimumab, Adbry (tralokinumab-ldm), Amjevita (adalimumab-atto), Arcalyst (rilonacept), Avsola (infliximab-axxq), Avtozma (tocilizumab-anoh), Benlysta (belimumab), Bimzelx (bimekizumab-bkzx), Cibirgo (abrocitinib), Cimzia (certolizumab), Cinqair (reslizumab), Cosentyx (secukinumab), Cyltezo (adalimumab-adbm), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Enbrel (etanercept), Entyvio (vedolizumab), Exdensur (depemokimab-ulaa), Fasenra (benralizumab), Hadlima (adalimumab-bwwd), Hulio (adalimumab-fkjp), Humira (adalimumab), Hyrimoz (adalimumab-adaz), Idacio (adalimumab-aacf), Ilaris (canakinumab), Ilumya (tildrakizumab-asmn), Imuldosa (ustekinumab-srlf), Inflectra (infliximab-dyyb), Infliximab, Kevzara (sarilumab), Kineret (anakinra), Leqselvi (deuruxolitinib), Litfulo (ritlectinib), Nemluvio (nemolizumab-ilto), Nucala (mepolizumab), Olumiant (baricitinib), Omlyclo (omalizumab-igec), Omvoh (mirikizumab-mrkz), Opzelura (ruxolitinib), Orenzia (abatacept), Otezla (apremilast), Otulfi (ustekinumab-aauz), Pyzchiva (ustekinumab-twe), Remicade (infliximab), Renflexis (infliximab-abda), Riabni (rituximab-arrx), Rinvoq (upadacitinib), Rituxan (rituximab), Rituxan Hycela (rituximab/hyaluronidase human), Ruxience (rituximab-pvvr), Saphnelo (anifrolumab-fnia), Selarsdi (ustekinumab-aekn), Siliq (brodalumab), Simlandi (adalimumab-ryvk), Simponi (golimumab), Simponi ARIA (golimumab), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Spevigo (spesolimab-sbzo) subcutaneous injection, Starjemma (ustekinumab-hmny), Stelara (ustekinumab), Steqeyma (ustekinumab-stba), Taltz (ixekizumab), Tezspire (tezepelumab-ekko), Tofacitinib, Tofidence (tocilizumab-bavi), Tremfya (guselkumab), Truxima (rituximab-abbs), Tyenne (tocilizumab-aazg), Tysabri (natalizumab), Velsipity (etrasimod), Wezlana (ustekinumab-auub), Xeljanz (tofacitinib), Xeljanz XR (tofacitinib extended release), Xolair (omalizumab), Yesintek (ustekinumab-kfce), Yuflyma (adalimumab-aaty), Yusimry (adalimumab-aqvh), Zeposia (ozanimod), Zymfentra (infliximab-dyyb)? .....  Yes  No  
 If yes, please specify agent: \_\_\_\_\_  
 If yes, does the prescribing information for the requested agent limit use with another immunomodulatory agent? .....  Yes  No  
 If no, is there support for the use of combination therapy (i.e., clinical trials, phase III studies, guidelines required)? **Please note, a submitted copy is required.** .....  Yes  No

**Please continue to the next page.**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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**For ulcerative colitis (UC) requests (continued):**

- **Please submit chart notes to support the answers to the following questions:**

13. Has the patient tried and had an inadequate response to TWO of the following agents: Adalimumab-aaty, Adalimumab-adbm (Quallent), Entyvio, Hadlima, Humira, Rinvoq, Simlandi, Skyrizi, Steqeyma, Stelara, Tremfya, Xeljanz/Xeljanz XR, Yesintek?.....  Yes  No
14. Were TWO of the following agents discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event: Adalimumab-aaty, Adalimumab-adbm (Quallent), Entyvio, Hadlima, Humira, Rinvoq, Simlandi, Skyrizi, Steqeyma, Stelara, Tremfya, Xeljanz/Xeljanz XR, Yesintek?.....  Yes  No  
 Does the patient have an intolerance (defined as an intolerance to the drug or its excipients, NOT to the route of administration) or hypersensitivity to TWO of the following agents: Adalimumab-aaty, Adalimumab-adbm (Quallent), Entyvio, Hadlima, Humira, Rinvoq, Simlandi, Skyrizi, Steqeyma, Stelara, Tremfya, Xeljanz/Xeljanz XR, Yesintek?.....  Yes  No  
 Does the patient have an FDA labeled contraindication to ALL of the following agents: Adalimumab-aaty, Adalimumab-adbm (Quallent), Entyvio, Hadlima, Humira, Rinvoq, Simlandi, Skyrizi, Steqeyma, Stelara, Tremfya, Xeljanz/Xeljanz XR, Yesintek?.....  Yes  No
15. Are TWO of the following agents expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm: Adalimumab-aaty, Adalimumab-adbm (Quallent), Entyvio, Hadlima, Humira, Rinvoq, Simlandi, Skyrizi, Steqeyma, Stelara, Tremfya, Xeljanz/Xeljanz XR, Yesintek? .....  Yes  No
16. Are TWO of the following agents not in the best interest of the patient based on medical necessity: Adalimumab-aaty, Adalimumab-adbm (Quallent), Entyvio, Hadlima, Humira, Rinvoq, Simlandi, Skyrizi, Steqeyma, Stelara, Tremfya, Xeljanz/Xeljanz XR, Yesintek?.....  Yes  No
17. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as TWO of the following agents and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event: Adalimumab-aaty, Adalimumab-adbm (Quallent), Entyvio, Hadlima, Humira, Rinvoq, Simlandi, Skyrizi, Steqeyma, Stelara, Tremfya, Xeljanz/Xeljanz XR, Yesintek? .....  Yes  No

**For renewal requests:**

18. Has the patient had clinical benefit with the requested agent? .....  Yes  No

**Please fax or mail this form to:**  
 Prime Therapeutics LLC  
 Clinical Review Department  
 2900 Ames Crossing Road Suite 200  
 Eagan, MN 55121

**TOLL FREE**

**Phone:** **Fax: 877.243.6930**  
**BCBSIL: 800.285.9426**  
**BCBSMT: 888.723.7443**  
**BCBSNM: 800.544.1378**  
**BCBSOK: 800.991.5643**  
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