Mountain Pacific
INNOVATING BETTER HEALTH

Mailing Address: P.O. Box 5119 | Helena, MT 59604
Phone: 406.443.6002 | Toll-free: 1.800.395.7961
Fax: 406.513.1928 | Toll-free: 1.800.294.1350

# Montana Healthcare Programs Prior Authorization Request Form for Use of Zeposia™ (ozanimod)

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|---|---|---|
| Member Name: | DOB: | Date: |
| Member ID: | Prescriber Phone: | |
| Prescriber Name/Specialty if applicable: | Prescriber Fax: | |
| Dosage Requested: | | |

**Please complete below information for applicable situation, Initiation or Continuation of therapy:**

## ☐ INITIATION OF THERAPY

Please check appropriate diagnosis and complete corresponding information:

**1. Multiple Sclerosis (MS):**

a. Member is 18 years of age or older: ☐ Yes ☐ No

b. Medication is prescribed by or in consultation with a neurology specialist: ☐ Yes ☐ No

**Action required:** If not in a specialty clinic or written by a specialist, copy of annual specialty consult with an appropriate specialist is required (please attach copy of consult):

**Name of specialist:** _____ **Contact date:** _____

c. Member has a diagnosis of:

☐ Clinical isolated syndrome (CIS)
☐ Relapsing-remitting MS (RRMS)
☐ Secondary progressive MS (SPMS)

d. Member has had an inadequate treatment response, intolerance or contraindication to a preferred MS agent:

☐ Yes ☐ No Name: _____ Dates of use: _____

**2. Moderate to Severe Ulcerative Colitis**

a. Member is 18 years of age or older: ☐ Yes ☐ No

b. Medication is prescribed by or in consultation with a gastroenterology specialist: ☐ Yes ☐ No

**Action required:** If not in a specialty clinic or written by a specialist, copy of annual specialty consult with an appropriate specialist is required (please attach copy of consult):

Name of specialist: _____ Contact date: _____

c. Member has a diagnosis moderate to severe ulcerative colitis: ☐ Yes ☐ No

d. Member has had an inadequate treatment response, intolerance or contraindication to a preferred tumor necrosis factor (TNF) blocker: ☐ Yes ☐ No

Name: _____ Dates of use: _____

**LIMITATIONS:**

- Initial dosing: 0.23mg once daily days 1-4, 0.46mg once daily days 5-7
- Maintenance dosing: 0.92mg once daily starting on day 8

**Initial authorization will be issued for 12 months for MS and 3 months for UC.**

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## ☐ CONTINUATION OF THERAPY

1. Multiple Sclerosis*:*
    a. Member has been adherent to therapy: ☐ Yes ☐ No
    b. Annual specialty consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A – Provider is the specialist.
2. Moderate to Severe Ulcerative Colitis:
    a. Member has been compliant with therapy: ☐ Yes ☐ No
    b. Documentation is **attached** showing positive clinical response (i.e., decreased stool frequency or rectal bleeding): ☐ Yes ☐ No

a. Annual specialty consult **attached** if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A – Provider is the specialist.

**Reauthorization will be issued for 12 months.**

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**Please complete form, including required attachments, and fax to:**
**Drug Prior Authorization Unit at 1-800-294-1350**

10/2023