

## Montana Healthcare Programs Prior Authorization Request Form for Use of Velsipity® (etrasimod)

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

1. Member has a diagnosis of moderately to severely active ulcerative colitis (UC): ☐ Yes ☐ No
2. Member is 18 years of age or older: ☐ Yes ☐ No
3. 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:** \_\_\_\_\_

4. Member has trialed and has had an inadequate treatment response, intolerance or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List [19 \(mt.gov\)](http://19.mt.gov) (unless preferred product[s] do not have the appropriate indication): ☐ Yes ☐ No

**Name:** \_\_\_\_\_ **Dates:** \_\_\_\_\_

5. Member has **NOT** experienced a myocardial infarction, unstable angina pectoris, stroke, transient ischemic attack (TIA), decompensated heart failure requiring hospitalization or Class III or IV heart failure in the last 6 months:  
☐ Yes ☐ No
6. Member has had **NO** history or presence of Mobitz type II second-degree or third-degree AV block, sick sinus syndrome or sino-atrial block, unless the member has a functioning pacemaker: ☐ Yes ☐ No
7. Provider attests to **all the following**:
  - Vaccines and lab work should be updated prior to Velsipity® initiation: ☐ Yes ☐ No
  - Member has had an EKG and eye exam prior to Velsipity® initiation: ☐ Yes ☐ No
  - Pertinent drug-drug interactions have been reviewed: ☐ Yes ☐ No
8. Provider attests that the member **will not** use Velsipity® concomitantly with other biologics: ☐ Yes ☐ No

### LIMITATIONS:

Maximum dose for initial authorization: 1 tablet daily

**Initial authorization will be issued for 12 weeks.**

**☐ CONTINUATION OF THERAPY**

1. Member has had positive clinical response to therapy (e.g., reduction in the frequency and/or severity of symptoms and exacerbations)? ☐ Yes ☐ No
2. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A - prescriber is specialist.
3. Provider attests the member will not use Velsipity® concomitantly with other biologics: ☐ Yes ☐ No

**LIMITATIONS:**

Maximum dose for renewal authorization: 1 tablet daily

**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.**