Multiple Sclerosis Agents: Ozanimod (Zeposia)

Please fax this completed form to (833) 645-2734 OR mail to: Centene Pharmacy Services | 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

Coordinated Care of Washington, Inc. Preferred Drug List: *https://www.coordinatedcarehealth.com/content/dam/centene/centene-pharmacy/pdl/FORMULARY-CoordinatedCare_Washington.pdf*

For policy criteria, see: https://www.coordinatedcarehealth.com/providers/resources/clinical-payment-policies.html

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of therapy? ☐ Yes ☐ No
   If yes, does patient have clinical documentation demonstrating disease stability or a positive clinical response? ☐ Yes ☐ No

2. Is this prescribed by, or in consultation with, any of the following? Check all that apply:
   ☐ Gastroenterologist ☐ Neurologist ☐ Other. Specify: _____

3. What is patient current weight: _____kg Date taken: _____

4. Indicate patient's diagnosis and answer the associated questions as indicated:
   ☐ Multiple Sclerosis (questions 5 - 10)
   ☐ Ulcerative Colitis (questions 11 – 15)

For diagnosis of Multiple Sclerosis:

5. Has patient had treatment with preferred Multiple Sclerosis medications on the Apple Health Preferred Drug List (AHPDL) that was ineffective, contraindicated or not tolerated?
   ☐ Yes. List each medication and duration of trial:

   Medication Name: _____ Duration: _____
   Medication Name: _____ Duration: _____
   Medication Name: _____ Duration: _____

   ☐ No. Explain why preferred products have not been tried: _____

6. Will the requested medication be used in combination with other disease modifying therapies (DMTs) for multiple sclerosis? ☐ Yes ☐ No

7. Does patient have diagnosis of any of the following? Check all that apply:
   ☐ Relapsing remitting disease (RRMS) ☐ Active secondary progressive disease (SPMS)
   ☐ Clinically isolated syndrome

8. Has diagnosis been confirmed and documented by a laboratory report (e.g. MRI)? ☐ Yes ☐ No

9. Have baseline assessments of any of the following been submitted? Check all that apply:
   ☐ Number of relapses per year
   ☐ Expanded disability status scale (EDSS score)

10. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (i.e., decrease in number of relapses per year, improvement in EDSS score)? ☐ Yes ☐ No

For diagnosis of Ulcerative Colitis:

11. Will the requested medication be used in combination with another Cytokine and CAM medication?
    ☐ Yes ☐ No

12. Has patient had treatment with preferred Cytokine and CAM medications on the Apple Health Preferred Drug List (AHPDL) that was ineffective, contraindicated or not tolerated?
    ☐ Yes. List each medication and duration of trial:

    Medication Name: _____ Duration: _____
    Medication Name: _____ Duration: _____
    Medication Name: _____ Duration: _____
    Medication Name: _____ Duration: _____
    Medication Name: _____ Duration: _____

    ☐ No. Explain why preferred products have not been tried: _____

13. Have baseline assessments been submitted (e.g., stool frequency, endoscopy results, presence of rectal bleeding, disease activity scoring tool)? ☐ Yes ☐ No

14. Has treatment with conventional therapy (e.g., systemic corticosteroids, azathioprine, mesalamine, sulfasalazine) been ineffective, unless all are contraindicated, or not tolerated [minimum trial of 12 weeks]?
    ☐ Yes ☐ No

15. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., decreased stool frequency, decreased rectal bleeding, improvement in endoscopic activity, tapering or discontinuation of corticosteroid therapy, or improvement on a disease activity scoring tool)?
    ☐ Yes ☐ No

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date

Centene Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)