BlueCross BlueShield
Federal Employee Program

ZEPOSIA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Zeposia (ozanimod)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

Will the patient need more than 90 capsules every 90 days? ❑Yes***** ❑No

If YES, please specify the requested quantity: _____ capsules every 90 days

1. Does the patient have a heart rate greater than or equal to 55 beats per minute? ❑Yes ❑No
2. Does the patient have a history (within the last six months) of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure? ❑Yes ❑No
3. Does the patient have a presence of Mobitz Type II 2nd degree or 3rd degree AV block, sick sinus syndrome, or sino-atrial block? ❑Yes***** ❑No

   If YES, does the patient have a pacemaker? ❑Yes ❑No
4. Does the patient have significant QTc prolongation (males QTcF greater than 450 msec, females greater than 470 msec)? ❑Yes ❑No
5. Does the patient have severe untreated sleep apnea? ❑Yes ❑No
6. Will the patient be given live vaccines while on Zeposia? ❑Yes ❑No
7. What is the patient's diagnosis?

   ❑Active secondary progressive disease multiple sclerosis **OR** ❑Clinically Isolated Syndrome (CIS) **OR**

   ❑Relapsing Multiple Sclerosis (MS) **OR** ❑Relapsing-remitting multiple sclerosis

   a. Has the patient been on Zeposia continuously for the last **6 months**, excluding samples? ❑Yes ❑No*****

      If NO, please answer the following questions:

      i. Has the prescriber obtained or will the prescriber obtain baseline live function tests (LFTs), complete blood count (CBC) including lymphocyte count, and electrocardiogram (ECG) evaluations prior to starting therapy? ❑Yes ❑No

      ii. Does the patient have a history of uveitis and/or diabetes? ❑Yes***** ❑No

      If YES, will an ophthalmic evaluation of the fundus, including the macula, be completed prior to initiation of therapy? ❑Yes ❑No

      iii. **Standard/Basic Option Patient**: Is Zeposia being requested as a change from Bafiertam, **brand** Aubagio, **brand** Gilenya, Extavia, Mavenclad, Ponvory, or Vumerity to allow the member access to their copay benefit? ❑Yes***** ❑No

      If YES, select medication: ❑Bafiertam ❑**Brand** Aubagio ❑**Brand** Gilenya ❑Extavia ❑Mavenclad ❑Ponvory ❑Vumerity

   b. Will Zeposia be used in combination with other MS disease modifying agents? ❑Yes***** ❑No

      If YES, please specify medication: _____

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Ulcerative Colitis (UC)

a. **Standard/Basic Option**: Humira including preferred Humira biosimilars, Rinvoq, Skyrizi, Stelara (SC), and Tremfya are preferred products. Patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year. Would you like to switch the patient to a preferred product? ***Please select answer below:***
❑Yes, switch to Humira ❑Yes, switch to Rinvoq ❑Yes, switch to Skyrizi ❑Yes, switch to Stelara (SC)
❑Yes, switch to Tremfya ❑No*****

****If NO***, does the patient have an intolerance or contraindication* or have they had an inadequate treatment response to TWO of the following preferred medications: Humira including preferred Humira biosimilars, Rinvoq, Skyrizi, Stelara SC, or Tremfya? ****Contraindications include (not all inclusive): allergy, autoantibody formation/lupus-like syndrome, or a history of congestive heart failure, hepatitis B virus infection, malignancy, or demyelinating disorder such as multiple sclerosis, Guillain-Barre syndrome, or optic neuritis.***

Please select answer: ❑Yes ❑No*

****If NO,*** is there a clinical reason for not trying TWO of the preferred medications? ❑Yes ❑No

b. Will Zeposia be used in combination with a biologic disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD for ulcerative colitis (e.g., Entyvio, Humira, Simponi, Stelara, Xeljanz)? ❑Yes***** ❑No

****If YES***, please specify medication: _____

c. Has the patient been on Zeposia continuously for the last **6 months**, excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Does the patient have moderately to severely active ulcerative colitis? ❑Yes ❑No

ii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least **ONE** conventional therapy option? ❑Yes ❑No

iii. Has the prescriber obtained or will the prescriber obtain baseline live function tests (LFTs), complete blood count (CBC) including lymphocyte count, and electrocardiogram (ECG) evaluations prior to starting therapy? ❑Yes ❑No

iv. Does the patient have a history of uveitis and/or diabetes? ❑Yes***** ❑No

****If YES***, will an ophthalmic evaluation of the fundus, including the macula, be completed prior to initiation of therapy? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

i. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No

❑Other diagnosis ***(please specify)***: _____