Prior Authorization Request Form for
ozanimod **(Zeposia)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the requested medication prescribed by a neurologist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have a documented diagnosis of relapsing forms of multiple sclerosis (MS)?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the patient concurrently using a disease-modifying therapy (for example, beta interferons [Avonex, Betaseron, Rebif, Plegridy, Extavia], glatiramer [Copaxone, Glatopa], dimethyl fumarate [Tecfidera], diroximel fumarate [Vumerity], monomethyl fumarate [Bafiertam], cladribine [Mavenclad], teriflunamide [Aubagio])?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **4**
4. Has the patient previously failed a treatment course of fingolimod (Gilenya)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **5**
5. Has the patient previously failed a treatment course of siponimod (Mayzent)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **6**
6. Does the provider acknowledge that all recommended Zeposia monitoring has been completed and the patient will be monitored throughout treatment as recommended in the label? Monitoring includes the following: • **complete blood count (CBC),** • **liver function tests (LFT),** • **varicella zoster virus (VZV) antibody serology,** • **electrocardiogram (ECG), and** • **macular edema screening as indicated**	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

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7. Will the requested medication be used in patients with significant cardiac history, including: • **Patients with a recent history (within the past 6 months) of class III/IV heart failure, myocardial infarction, unstable angina, stroke, transient ischemic attack, or decompensated heart failure requiring hospitalization** • **Patients with a history or presence of Mobitz type II second-degree or third-degree atrioventricular (AV) block or sick sinus syndrome, unless they have a functioning pacemaker?**	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.**
Please sign and date:

Prescriber Signature _____ Date _____

[11 November 2020]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: