US Family Health Plan
Prior Authorization Request Form for
ozanimod (**Zeposia**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

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]