PRIOR AUTHORIZATION REQUEST

ZEPOSIA

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is the request an INITIAL or CONTINUATION of therapy?

[] Initial (If checked, go to 7)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 7.]

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3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved PA on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has experienced a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	Has documentation been provided to confirm that the patient has completed ALL of the following: A) Complete blood count including lymphocyte count (within the last 6 months or after discontinuation of prior MS therapy), B) Electrocardiogram (ECG), C) Transaminase and bilirubin levels (within the last 6 months), D) Ophthalmic evaluation, E) Current medication evaluation for immunosuppressive therapies, F) Varicella Zoster vaccination or titers? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
8	Does the patient have an active infection? [If yes, no further questions.]	Yes	No
9	Has the patient received any live or live-attenuated vaccinations 4 weeks prior to initiation of the requested medication? [If yes, no further questions.]	Yes	No
10	Does the patient have ANY of the following FDA labeled contraindications: A) History (within the last 6 months) of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or NYHA Class III/IV heart failure, B) History or presence of Mobitz Type II second or third degree AV block, sick sinus syndrome, or sino-atrial block (unless patient has a functioning pacemaker), C) Severe untreated sleep apnea, or D) Concomitant use of a monoamine oxidase inhibitor? [If yes, no further questions.]	Yes	No
11	What is the indication or diagnosis?		
	[] Multiple sclerosis (If checked, go to 12)		
	[] Ulcerative colitis (If checked, go to 19)		

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	[] Other (If checked, no further questions)		
12	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
13	Does the patient have multiple sclerosis with non-relapsing forms of the disease? [Note: An example of a non-relapsing form of multiple sclerosis is primary progressive multiple sclerosis.] [If yes, no further questions.]	Yes	No
14	Does the patient have a relapsing form of multiple sclerosis? [Note: Examples of relapsing forms of multiple sclerosis include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease.] [If no, no further questions.]	Yes	No
15	Will the requested medication be used in combination with other disease-modifying agents used for multiple sclerosis? [Note: Examples include Aubagio (teriflunomide tablets), Avonex (interferon beta-1a intramuscular injection), Bafiertam (monomethyl fumarate delayed-release capsules), and others.] [If yes, no further questions.]	Yes	No
16	Has the patient had a documented intolerance, contraindication to, or failed treatment for at least 3 months with at least TWO preferred agents such as dimethyl fumarate, Copaxone (glatiramer acetate), teriflunomide (Aubagio), fingolimod (Gilenya)? [If no, no further questions.]	Yes	No
17	Is the requested medication being prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of multiple sclerosis? [If no, no further questions.]	Yes	No
18	Does the prescribed dosing exceed the FDA approved indication? (Dosing: 0.92 mg orally once daily.) [No further questions.]	Yes	No
19	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
20	Does the patient have a documented diagnosis of moderately to severely active ulcerative colitis? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
21	Will the patient be using the requested medication in combination with other biologics or targeted synthetic disease- modifying antirheumatic drugs (DMARDs)? [Note: Examples include Xeljanz/Xeljanz XR (tofacitinib tablets/extended-release	Yes	No

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	tablets).] [If yes, no further questions.]		
22	Has the patient had a trial of TWO systemic agent for ulcerative colitis or was intolerant to systemic agent? [Note: Examples include 6-mercaptopurine, azathioprine, cyclosporine, tacrolimus, or a corticosteroid such as prednisone or methylprednisolone.] [If no, no further questions.]	Yes	No
23	Has documentation been submitted to confirm that the patient has moderate to severe symptoms? ACTION REQUIRED: Submit supporting documentation. [Note: Examples include Mayo endoscopy sub-score greater than or equal to 2, greater than 6 bowel movement per day, greater than or equal to 4 bloody stools per day, hemoglobin less than 75% normal (males less than 10 g/dL, females less than 9 g/dL).] [If yes, skip to question 28.]	Yes	No
24	Has documentation been submitted to confirm that the patient has mildly active symptoms with poor prognosis factors for disease severity? ACTION REQUIRED: Submit supporting documentation. [Note: Examples include Mayo endoscopy sub-score equal to 3, extensive colitis, corticosteroid dependence (unable to taper after 3 months of continuous therapy), elevated CRP greater than or equal to 10 mg/dL, low serum album less than 3.4 mg/dL.] [If yes, skip to question 28.]	Yes	No
25	Does the patient have documented intolerance, contraindication to, or failed treatment for at least 3 months with preferred TNF inhibitor, an adalimumab product (Hadlima, Yusimry, Simlandi, or adalimumab-adbm)? [If no, no further questions.]	Yes	No
26	Does the patient have documented intolerance, contraindication to, or failed treatment for at least 3 months with preferred JAK inhibitor, Xeljanz (tofacitinib)? [If no, no further questions.]	Yes	No
27	Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred ustekinumab product (Yesintek, Pyzchiva, Steqeyma) for at least 3 months or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 29.] [If no, no further questions.]	Yes	No
28	Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with a preferred Infliximab product? ACTION REQUIRED: Submit supporting documentation. [Note: Infusion dates and dosages required.] [If no, no further questions.]	Yes	No

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29	Is the requested medication being prescribed by or in consultation with a gastroenterologist? [If no, no further questions.]	Yes	No
30	Does the prescribed dosing exceed the FDA approved indication? [Note: Dosing is 0.92 mg orally once daily.]	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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