HEALTH PARTNERS PLANS
Phone 215-991-4300 Fax 1-866-240-3712

FAX FORM AND CLINICAL DOCUMENTATION

ULCERATIVE COLITIS AGENTS PRIOR AUTHORIZATION FORM *(form effective 1/8/2024)*

Prior authorization guidelines for **Ulcerative Colitis Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	total pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Dosage form:	Strength:	
Directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code *(required)*:	
Is the beneficiary currently being treated with the requested medication?	☐Yes – date of last dose: _____ *Submit documentation.* ☐No		

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

1. **For a SPHINGOSINE 1-PHOSPHATE RECEPTOR (S1PR) MODULATOR (eg, VELSIPITY [etrasimod], ZEPOSIA [ozanimod]) for treatment of ulcerative colitis (UC):**
   - ☐Is prescribed the medication by or in consultation with an appropriate specialist (eg, a gastroenterologist)
   - ☐Has moderate-to-severe UC
   - ☐Has UC associated with multiple poor prognostic factors
   - ☐Tried and failed to achieve remission with or has a contraindication or an intolerance to an induction course of corticosteroids
   - ☐Tried and failed to maintain remission with or has a contraindication or an intolerance to conventional immunomodulators (eg, AZA, cyclosporine, 6-MP, MTX)
   - ☐Has achieved remission with the requested medication AND:
     - ☐Will be using the requested medication as maintenance therapy to maintain remission

☐ Tried and failed or has a contraindication or an intolerance to the preferred Cytokine and CAM Antagonists that are FDA-approved or medically accepted for the treatment of UC. (*Refer to https://papdl.com/preferred-drug-list for a list of preferred Cytokine and CAM Antagonists.)*

☐ **Request is for VELSIPITY (etrasimod) AND:**
- ☐ Has a comorbid heart condition – describe: _____
- ☐ Experienced any of the following in the past 6 months:
  - ☐ Myocardial infarction
  - ☐ Unstable angina
  - ☐ Stroke
  - ☐ Transient ischemic attack
  - ☐ Decompensated heart failure requiring hospitalization
  - ☐ Class III or IV heart failure

☐ **Request is for ZEPOSIA (ozanimod) AND:**
- ☐ Has severe untreated sleep apnea
- ☐ Will be taking a monoamine oxidase (MAO) inhibitor while taking Zeposia (e.g., selegiline, phenelzine)
- ☐ Has a comorbid heart condition – describe: _____
- ☐ Experienced any of the following in the past 6 months:
  - ☐ Myocardial infarction
  - ☐ Unstable angina
  - ☐ Stroke
  - ☐ Transient ischemic attack
  - ☐ Decompensated heart failure requiring hospitalization
  - ☐ Class III or IV heart failure

2. For all other NON-PREFERRED Ulcerative Colitis Agents:

☐ Tried and failed or has a contraindication or an intolerance to the preferred Ulcerative Colitis Agents approved or medically accepted for the beneficiary's condition *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

RENEWAL requests

1. For a SPHINGOSINE 1-PHOSPHATE RECEPTOR (S1PR) MODULATOR (eg, VELSIPITY [etrasimod], ZEPOSIA [ozanimod]):

☐ Is prescribed the medication by or in consultation with an appropriate specialist (eg, a gastroenterologist)

☐ Experienced improvement in disease activity or level of functioning since starting the requested medication

☐ **Request is for VELSIPITY (etrasimod) AND:**
- ☐ Has a comorbid heart condition – describe: _____
- ☐ Experienced any of the following in the past 6 months:
  - ☐ Myocardial infarction
  - ☐ Unstable angina
  - ☐ Stroke
  - ☐ Transient ischemic attack
  - ☐ Decompensated heart failure requiring hospitalization
  - ☐ Class III or IV heart failure

☐ **Request is for ZEPOSIA (ozanimod) AND:**
- ☐ Has severe untreated sleep apnea
- ☐ Will be taking a monoamine oxidase inhibitor while taking Zeposia (e.g., selegiline, phenelzine)
- ☐ Has a comorbid heart condition – describe: _____
- ☐ Experienced any of the following in the past 6 months:
  - ☐ Myocardial infarction
  - ☐ Unstable angina
  - ☐ Stroke
  - ☐ Transient ischemic attack
  - ☐ Decompensated heart failure requiring hospitalization
  - ☐ Class III or IV heart failure

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 866-240-3712

Prescriber Signature:	**Date**: