

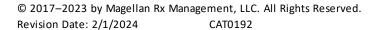
Zeposia (ozanimod) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME:		MEMBER'S FIRST NAME:		
mportant for the review (additional documentation that is equest). Information contained in	
IIIS IUIIII IS FIULECLEU HEA	III IIIIOI IIIduon unuei miraa.		☐ URGENT	
MEMBER INFORMATION	N			
LAST NAME:		FIRST NAME:		
PHONE NUMBER:		DATE OF BIRTH:		
STREET ADDRESS:		•		
CITY:		STATE: ZIP CC	DDE:	
PATIENT INSURANCE ID	NUMBER:	•		
FYOU ARE NOT THE PATIENT OR THE PE COLLOWING LINK: HTTPS://MAGELLANI	HEIGHT (IN/CM): WI RESCRIBER, YOU WILL NEED TO SUBMIT A PHI IE RX.COM/MEMBER/EXTERNAL/COMMERCIAL/ REPRESENTATIVE (IF APPLICAB	DISCLOSURE AUTHORIZATION FORM WITH TH COMMON/DOC/EN-US/PHI DISCLOSURE A	HIS REQUEST WHICH CAN BE FOUND AT THE AUTHORIZATION.PDF	
AUTHORIZED REPRESENT PRESCRIBER INFORMAT	ATIVE'S PHONE NUMBER: ION			
LAST NAME:		FIRST NAME:		
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:		
NPI NUMBER:		DEA NUMBER:		
PHONE NUMBER:		FAX NUMBER:		
STREET ADDRESS:		·		
CITY:		STATE: ZIP CODE:		
REQUESTOR (if different than prescriber):		OFFICE CONTACT PERSO	OFFICE CONTACT PERSON:	
		-	•	
MEDICATION OR MEDIC	CAL DISPENSING INFORMATION	ON		
MEDICATION NAME:				
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:	
■ NEW THERAPY	☐ RENEWAL	IF RENEWAL: DATE THE	RAPY INITIATED:	
DURATION OF THERAPY	(SPECIFIC DATES):			

Continued on next page.



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MEMBER'S LAST NAME:	MEMBER'S FIRST	NAME:		
1. HAS THE PATIENT TRIED ANY OTHE	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:		
2. LIST DIAGNOSES:		ICD-10:		
 □ Clinically Isolated Syndrome (CIS) □ Relapsing Remitting Multiple Sclerosis □ Secondary Progressive Multiple Sclero □ Ulcerative Colitis (UC) 	osis (SPMS)	165-10.		
□ Other diagnosis:	ICD-10:			
3. REQUIRED CLINICAL INFORMATION PRIOR AUTHORIZATION. Clinical Information:	N: PLEASE PROVIDE ALL RELEVANT CLIN	ICAL INFORMATION TO SUPPORT A		
Is drug going to be used in conjuncti	ion with a clinical trial? 🗆 Yes 🗆 No			
Initial Request for Multiple Sclerosis:				
Is the prescriber a neurologist? Yes No				
Has patient had a 3 month trial each dimethyl fumarate fingolimod glatiramer acetate teriflunomide	of at least 2 of the following? □ Yes □ I	No Please provide documentation.		
Initial Request for Ulcerative Colitis: Is the prescriber a gastroenterologis	t? □Yes □No			
Does patient have Crohn's disease o	r indeterminate colitis? ☐ Yes ☐ No <i>Ple</i>	ase provide documentation.		
Has patient tried and failed at least of mercaptopurine? Yes No Please	one of the following three therapies: co	rticosteroids, azathioprine and/or 6-		
Has patient tried and failed at least t documentation.	hree months of Humira(adalimumab)?	□ Yes □ No Please submit chart		
Will patient use requested medication	on in combination with another biologi	c response modifier? □ Yes □ No		
Renewal Request: Is prescriber a neurologist? Yes	No			
Is prescriber a gastroenterologist?	⊐Yes □No			

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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:			
Is patient continuing to have a positive respon	nse to therapy? 🗆 Yes 🗆 No Please submit chart documentation.			
Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?				
*Please note: Not all drugs/diagnoses are cover information is received.	red on all plans. This request may be denied unless all required			
•	d is true and accurate to the best of my knowledge. I understand that esignees may perform a routine audit and request the medical the information reported on this form.			
Prescriber Signature or Electronic I.D. Verification	on:Date:			
you are not the intended recipient, you are hereby notified	this transmission contain confidential health information that is legally privileged. If a that any disclosure, copying, distribution, or action taken in re liance on the contents wed this information in error, please notify the sender immediately (via return FAX) ents.			

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program

Attn: CP – 4201 P.O. Box 64811 St. Paul, MN 55164-0811

> Magellan Rx MANAGEMENTS

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