TEXAS MEDICAID
Clinical Edit Prior Authorization
ozanimod (ZEPOSIA)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: CLINICAL PRIOR AUTHORIZATION CRITERIA

☐ Indicate Primary Diagnosis: _____ ICD 10 Code: _____

1. Is the client greater than or equal to (≥) 18 years of age?

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client have a diagnosis of multiple sclerosis (MS) in the last 730 days?

   ☐ Yes (Go to #3) ☐ No (Deny)

3. Does the client have a diagnosis of severe hepatic impairment in the last 365 days?

   ☐ Yes (Deny) ☐ No (Go to #4)

4. Is the medication being prescribed concurrently with other disease modifying therapies for MS?

   Examples of disease modifying therapies include AUBAGIO, AVONEX PEN, BAFIERTAM DR, BETASERON, glatiramer (COPAXONE), dimethyl fumarate (TECFIDERA), EXTAVIA, GILENYA, GLATOPA, KESIMPTA, MAYZENT, mitoxantrone, PLEGRIDY, REBIF, REBIF REBIDOSE, VUMERITY, and ZEPOSIA

   ☐ Yes (Deny) ☐ No (Go to #5)

5. Does the client have a diagnosis of one of the following in the last 180 days?
   - myocardial infarction (MI)
   - unstable angina
   - stroke
   - decompensated heart failure requiring hospitalization
   - transient ischemic attack (TIA)
   - Class III/IV heart failure

   ☐ Yes (Deny) ☐ No (Go to #6)

6. Does the client have a history of Mobitz type II second-degree, third degree atrioventricular (AV) block, sick sinus syndrome or sino-atrial block (unless the client has a functioning pacemaker) in the last 180 days?

   ☐ Yes (Deny) ☐ No (Go to #7)

7. Does the client have a history of severe untreated sleep apnea in the last 365 days?

   ☐ Yes (Deny) ☐ No (Go to #8)

8. Does the client have a claim for a monoamine oxidase inhibitor (MAOI), strong CYP2C8 inhibitor/inducer or BCRP inhibitor in the last 90 days?

   ☐ Yes (Deny) ☐ No (Go to #9)

9. Is the requested dose less than or equal to (≤) 1 capsule/day?

   ☐ Yes (Approve – 365 days) ☐ No (Deny)

STEP 3: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.