Clinical Policy: Ozanimod (Zeposia)

Reference Number: PA.CHIP.PHAR.462
Effective Date: 01/2026
Last Review Date: 10/2025

Description
Ozanimod (Zeposia®) is a sphingosine 1-phosphate receptor modulator.

FDA Approved Indication(s)
Zeposia is indicated for the treatment of:

- Relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.
- Moderately to severely active ulcerative colitis (UC) in adults.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that the member has met all approval criteria.

It is the policy of PA Health & Wellness® that Ozanimod (Zeposia) is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Multiple Sclerosis (must meet all)**:**

1. Diagnosis of one of the following (a, b, or c):
   a. Clinically isolated syndrome, and member is contraindicated to both, or has experienced clinically significant adverse effects to one, of the following at up to maximally indicated doses: an **interferon-beta agent** (Avonex®, Betaseron®/Extavia®†, Rebif®, or Plegridy®), **glatiramer** (Copaxone®, Glatopa®);
   b. Relapsing-remitting MS, and failure of all of the following at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated (i, ii, iii, and iv):
   - **Dimethyl fumarate** (generic Tecfidera®);
   - **Teriflunomide** (generic Aubagio®);
   - **Fingolimod** (Gilenya®);
   - An **interferon-beta agent** (Avonex, Betaseron/Extavia, Rebif, or Plegridy) or **glatiramer** (Copaxone, Glatopa);
     **Prior authorization is required for all disease modifying therapies for MS*

   c. Secondary progressive MS;
2. Prescribed by or in consultation with a neurologist;
3. Age ≥ 18 years;
4. Zeposia is not prescribed concurrently with other disease modifying therapies for MS (*see Appendix D*);
5. Dose does not exceed the following (a and b):
   a. 0.92 mg per day;
   b. 1 capsule per day.

   Approval duration: 6 months

B. Ulcerative Colitis (must meet all)**:**

1. Diagnosis of UC;
2. Prescribed by or in consultation with a gastroenterologist;
3. Age ≥ 18 years;
4. Documentation of a Mayo Score ≥ 6 or modified Mayo Score ≥ 5 (*see Appendix E*);
5. Failure of an 8-week trial of systemic corticosteroids, unless contraindicated or clinically significant adverse effects are experienced;
6. Failure of one of the following, used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (a or b):
   a. One adalimumab product (e.g., *Hadlima, Simlandi, Yusimry, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, and adalimumab-fkjp are preferred*), unless the member has had a history of failure of two TNF blockers;
   b. One ustekinumab product (e.g. *Otulfi®, Pyzchiva® (branded), Steqeyma®, Yesintek™ are preferred*);

**Prior authorization may be required for adalimumab products and ustekinumab products*

7. Dose does not exceed the following (a and b):
   a. 0.92 mg per day;
   b. 1 capsule per day.

   Approval duration: 6 months

C. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Multiple Sclerosis (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Fidelis benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy;
3. Zeposia is not prescribed concurrently with other disease modifying therapies for MS (*see Appendix D*);
4. If request is for a dose increase, new dose does not exceed the following (a and b):
   a. 0.92 mg per day;
   b. 1 capsule per day.

Approval duration: 12 months

B. Ulcerative Colitis (must meet all):
1. Currently Member meets one of the following (a or b):
   a. Currently receiving medication via Fidelis benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed the following (a and b):
   a. 0.92 mg per day;
   b. 1 capsule per day.

Approval duration: 12 months

C. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

D. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53 for Medicaid or evidence of coverage documents;

E. Primary progressive MS.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration MS: multiple sclerosis

UC: ulcerative colitis

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
teriflunomide (Aubagio®)	**MS** 7 mg or 14 mg PO QD	14 mg/day
Avonex®, Rebif® (interferon beta-1a)	**MS** *Avonex*: 30 mcg IM Q week *Rebif*: 22 mcg or 44 mcg SC TIW	*Avonex*: 30 mcg/week *Rebif*: 44 mcg TIW
Betaseron®, Extavia® (interferon beta-1b)	**MS** 250 mcg SC QOD	250 mg QOD
Plegridy® (peginterferon beta-1a)	**MS** 125 mcg SC Q2 weeks	125 mcg/2 weeks
glatiramer acetate (Copaxone®, Glatopa®)	**MS** 20 mg SC QD or 40 mg SC TIW	20 mg/day or 40 mg TIW
fingolimod (Gilenya®)	**MS** 0.5 mg PO QD	0.5 mg/day
dimethyl fumarate (Tecfidera®)	**MS** 120 mg PO BID for 7 days, followed by 240 mg PO BID	480 mg/day
corticosteroids	**UC** budesonide (Uceris®) 9 mg PO QD	budesonide 9 mg/day
Hadlima (adalimumab-bwwd), Simlandi (adalimumab-ryvk), Yusimry (adalimumab-aqvh), adalimumab-aaty (Yuflyma®), adalimumab-adaz (Hyrimoz®), adalimumab-fkjp (Hulio®), adalimumab-adbm (Cyltezo®)	**UC** Initial dose: 160 mg SC on Day 1, then 80 mg SC on Day 15 Maintenance dose: 40 mg SC every other week starting on Day 29	40 mg every other week
Otulfi® (ustekinumab-aauz), Pyzchiva® (ustekinumab-ttwe), Steqeyma® (ustekinumab-stba),	**UC** Weight based dosing IV at initial dose: Weight ≤ 55 kg: 260 mg Weight > 55 kg to 85 kg: 390 mg Weight > 85 kg: 520 mg	90 mg every 8 weeks

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Yesintek™ (ustekinumab-kfce)	Maintenance dose: 90 mg SC every 8 weeks	

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): history of any of the following in the last 6 months: myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III or IV heart failure; presence of Mobitz type II second-degree or third degree atrioventricular (AV) block, sick sinus syndrome, or sino-atrial block, unless the patient has a functioning pacemaker; severe untreated sleep apnea; concomitant use of a monoamine oxidase inhibitor
- Boxed warning(s): none reported

Appendix D: General Information

- Disease-modifying therapies for MS are: glatiramer acetate (Copaxone®, Glatopa®), interferon beta-1a (Avonex®, Rebif®), interferon beta-1b (Betaseron®, Extavia®), peginterferon beta-1a (Plegridy®), dimethyl fumarate (Tecfidera®), diroximel fumarate (Vumerity®), monomethyl fumarate (Bafiertam™), fingolimod (Gilenya®, Tascenso ODT™), teriflunomide (Aubagio®), alemtuzumab (Lemtrada®), mitoxantrone (Novantrone®), natalizumab (Tysabri®, and biosimilar Tyruko®), ocrelizumab (Ocrevus®), ocrelizumab/hyaluronidase-ocsq (Ocrevus Zunovo™), siponimod (Mayzent®), cladribine (Mavenclad®), ozanimod (Zeposia®), ponesimod (Ponvory™), ublituximab-xiiy (Briumvi™), and ofatumumab (Kesimpta®).
- The American Academy of Neurology 2018 MS guidelines recommend the use of Gilenya, Tysabri, and Lemtrada for patients with highly active MS. Definitions of highly active MS vary and can include measures of relapsing activity and MRI markers of disease activity, such as numbers of gadolinium-enhanced lesions.
- Of the disease-modifying therapies for MS that are FDA-labeled for clinically isolated syndrome, only the interferon products, glatiramer, and Aubagio have demonstrated any efficacy in decreasing the risk of conversion to MS compared to placebo. This is supported by the American Academy of Neurology 2018 MS guidelines.
- TNF blockers:
  - Etanercept (Enbrel®), adalimumab (Humira®) and its biosimilars, infliximab (Remicade®) and its biosimilars (Avsola™, Renflexis™, Inflectra®), certolizumab pegol (Cimzia®), and golimumab (Simponi®, Simponi Aria®).

Appendix E: Mayo Score or modified Mayo Score

- Mayo Score: evaluates UC stage, based on four parameters: stool frequency, rectal bleeding, endoscopic evaluation and Physician's global assessment. Each parameter of the score ranges from zero (normal or inactive disease) to 3 (severe activity) with an overall score of 12.

Score	Decoding
0 – 2	Remission
3 – 5	Mild activity
6 – 10	Moderate activity
> 10	Severe activity

- Modified Mayo Score: developed from the full Mayo score and evaluates ulcerative colitis stage, based on three parameters: stool frequency, rectal bleeding, and endoscopic evaluation. The modified Mayo Score gives a maximum overall score of 9. The FDA currently accepts the modified Mayo Score for the assessment of disease activity in pivotal UC clinical trials.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
MS, UC	Days 1-4: 0.23 mg PO QD Days 5-7: 0.46 mg PO QD Day 8 and thereafter: 0.92 mg PO QD; in patients with mild or moderate chronic hepatic impairment (Child-Pugh class A or B), QOD dosing is recommended If a dose of Zeposia is missed during the first 2 weeks of treatment, reinitiate treatment using the titration regimen. If a dose of Zeposia is missed after the first 2 weeks of treatment, continue with the treatment as planned.	0.92 mg/day

VI. Product Availability

Capsules: 0.23 mg, 0.46 mg, 0.92 mg

VII. References

1. Zeposia Prescribing Information. Summit, NJ: Celgene Corporation; August 2024. Available at: https://www.zeposia.com. Accessed January 24, 2025.
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3. Comi G, Kappos L, Selmaj KW, et al. Safety and efficacy of ozanimod versus interferon beta-1a in relapsing multiple sclerosis (SUNBEAM): a multicentre, randomised, minimum 12-month, phase 3 trial. Lancet Neurol. 2019; 18 (11): 1009-1020. doi:10.1016/S1474-4422(19)30239-X.
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5. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA Clinical practice guidelines on the management of moderate to severe ulcerative colitis. Gastroenterology 2020;158:1450–1461. https://doi.org/10.1053/j.gastro.2020.01.006.
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9. Singh S, Loftus EV Jr, Limketkai BN, et al. AGA Living Clinical Practice Guideline on Pharmacological Management of Moderate-to-Severe Ulcerative Colitis. Gastroenterology. 2024 Dec;167(7):1307-1343. doi: 10.1053/j.gastro.2024.10.001. PMID: 39572132.

Reviews, Revisions, and Approvals	Date
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