ULCERATIVE COLITIS AGENTS PRIOR AUTHORIZATION FORM *(form effective 1/5/2026)*

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

Prior authorization guidelines for **Ulcerative Colitis Agents** and **Quantity Limits/Daily Dose Limits** are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html.

☐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:	
Member name:		City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

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

Complete all sections that apply to the member 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 drug by or in consultation with an appropriate specialist (eg, a gastroenterologist)
   ☐Has moderate-to-severe UC
   ☐Has UC associated with multiple poor prognostic factors
   ☐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 *(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 844-205-3386

Prescriber Signature:	**Date**:

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)