

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

Prior authorization guidelines for **Ulcerative Colitis Agents** and **Quantity Limits/Daily Dose Limits** are available on Geisinger Health Plan's website at <https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger>.

<input type="checkbox"/> New request <input type="checkbox"/> 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 (<i>submit documentation</i>):		Dx code (<i>required</i>):	
Is the beneficiary currently being treated with the requested medication?	<input type="checkbox"/> Yes – date of last dose: _____ <i>Submit documentation.</i> <input type="checkbox"/> 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 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:
- | | |
|--|--|
| <input type="checkbox"/> Myocardial infarction | <input type="checkbox"/> Transient ischemic attack |
| <input type="checkbox"/> Unstable angina | <input type="checkbox"/> Decompensated heart failure requiring hospitalization |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> 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:
- | | |
|--|--|
| <input type="checkbox"/> Myocardial infarction | <input type="checkbox"/> Transient ischemic attack |
| <input type="checkbox"/> Unstable angina | <input type="checkbox"/> Decompensated heart failure requiring hospitalization |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> 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:
- | | |
|--|--|
| <input type="checkbox"/> Myocardial infarction | <input type="checkbox"/> Transient ischemic attack |
| <input type="checkbox"/> Unstable angina | <input type="checkbox"/> Decompensated heart failure requiring hospitalization |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> 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:
- | | |
|--|--|
| <input type="checkbox"/> Myocardial infarction | <input type="checkbox"/> Transient ischemic attack |
| <input type="checkbox"/> Unstable angina | <input type="checkbox"/> Decompensated heart failure requiring hospitalization |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Class III or IV heart failure |

Please submit to PromptPA <https://ghp.promptpa.com>

OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:

Date:

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