[Date] [Patient’s Name]

[Health Plan Name] [Date of Birth]

ATTN: [Department] Patient Policy ID Number: [ID #]

[Medical/Pharmacy Director Name (if available)] Reference Number: [# if available]

[Health Plan Address] [Dates of Service]

[City, State ZIP]

Re: Letter of Medical Necessity for ZEPOSIA® (ozanimod) capsules

Dear [Medical/Pharmacy Director Name],

I am writing on behalf of [patient’s name] to request coverage for ZEPOSIA® (ozanimod), for the treatment of [diagnosis], ICD-10-CM diagnosis code [diagnosis code]. This letter provides the clinical rationale and relevant information about the patient’s medical history and treatment.

ZEPOSIA is a sphingosine 1-phosphate (S1P) receptor modulator that was approved by the US Food and Drug Administration (FDA) in 2020 for the treatment of adults with relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease.

The patient is [a/an age]-year-old [male/female/other gender identification] who was diagnosed with [diagnosis] on [date]. Below is a rationale for prescribing ZEPOSIA based on my patient’s disease summary.

• [Insert disease summary]

I have prescribed ZEPOSIA, and am requesting this coverage because [insert reason(s) for medical necessity]. Please see attached documents to support my clinical findings.

Considering the patient’s history and condition, I believe treatment with ZEPOSIA is medically necessary for my patient. Please contact me at [physician’s phone number] or via email at [physician’s email] should you have questions or need additional information.

Thank you for your time and immediate attention to this request.

Sincerely,

[Provider name, contact information, and signature]

Enclosures: [List and attach additional documents to support your treatment rationale]