[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 requesting approval for use of 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]. 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.

I have reviewed your drug coverage policy and believe that the appropriate treatment decision at this time is to initiate treatment with ZEPOSIA. This letter outlines the patient’s medical history and previous treatments (if applicable) that support my recommendation for ZEPOSIA as the appropriate treatment option.

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 eg, relapse history and/or description of patient’s RMS disease progression, magnetic resonance imaging (MRI) scan documentation and findings, Expanded Disability Status Scale (EDSS) score, if available.]

• [If appropriate, insert past drugs and treatments that were tried and failed and patient’s response to these therapies (eg, intolerable side effects to alternate RMS therapies).]

• [Brief description of the patient’s recent conditions, and any other patient characteristics or relevant clinical considerations.]

I have prescribed ZEPOSIA and am requesting this coverage because of the following rationale:

• [Please provide clinical rationale for treatment.]

• [If applicable, please provide additional supporting information (eg, patient-specific data, information from the ZEPOSIA Prescribing Information, clinical trial data that may be relevant to the patient’s treatment, and/or clinical peer-reviewed literature).]

• [If applicable, provide appropriate state step-therapy legislation evidence, include statute (if available).]

Considering the patient’s history and condition, I believe treatment with ZEPOSIA is the appropriate option 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]