[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: Request for Formulary Exception 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]. Currently ZEPOSIA is not on your formulary. I am requesting an exception for ZEPOSIA to be available as a preferred drug and that any applicable National Drug Code (NDC) blocks be removed so a prescription for my patient may be filled.

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. In my clinical opinion, ZEPOSIA would be beneficial to the patient.

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]

The patient has been previously treated with other MS medications prior to this one, including [list of previous therapies]. The main reasons for requesting this exception are [insert main reasons for exception]. These reasons are supported by the attached information.

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, need additional information, or to participate in a peer-to-peer review to discuss treatment with ZEPOSIA.

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]