[Date] Name: [Patient’s Name]

[Health Plan Name] DOB: [XX/XX/XXXX]

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

[Medical/Pharmacy Director Name] Reference Number: [Reference #]

[Health plan address] Date(s) of Service: [XX/XX/XXXX]

[City, State Zip]

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

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], *International Classification of Diseases, 10th Revision, Clinical Modification* diagnosis code [diagnosis code]. 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 provides the clinical rationale and relevant information about the patient’s medical history.

ZEPOSIA is a sphingosine 1-phosphate receptor modulator that was approved by the US Food and Drug Administration in 2021 for the treatment of moderately to severely active ulcerative colitis (UC) in adults.

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

[Insert disease summary]

I 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]