PREFERRED SPECIALTY MANAGEMENT POLICY

POLICY: Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies – **Choice/Alternate**

- Zeposia® (ozanimod capsules – Celgene/Bristol Myers Squibb)

REVIEW DATE: 09/10/2025; effective 10/01/2025

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Zeposia, a sphingosine 1-phosphate receptor modulator, is indicated for the following uses:[1]

- **Relapsing forms of multiple sclerosis**, to include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease in adults.
- **Ulcerative colitis**, in adults with moderately to severely active disease.

For more information on criteria within a Prior Authorization program by specific condition, refer to the standard *Multiple Sclerosis and Ulcerative Colitis (Oral – Sphingosine 1-Phosphate Receptor Modulator) – Zeposia Prior Authorization Policy.*

Preferred and Non-Preferred Products.[¥]

	Multiple Sclerosis	Ulcerative Colitis
Step 1 **Preferred**	• Zeposia	• Adalimumab Products[^] Cyltezo/adalimumab-adbm, adalimumab-adaz, Simlandi/adalimumab-ryvk • Omvoh SC • Skyrizi SC (on-body injector) • Ustekinumab SC Products[*] – Stelara SC, Imuldosa SC, Selarsdi SC, Ustekinumab-ttwe SC, Yesintek SC • Tremfya SC • Velsipity • Zymfentra
Step 2 **Non-Preferred** (directed to **TWO** Step 1 Products)	--	• Zeposia

[¥] For Non-Preferred Adalimumab Products, refer to the *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies – Alternate* or the *Choice* version of that policy. For Non-Preferred ustekinumab SC products, refer to the *Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies – Alternate* or the *Choice* version of that policy. Note that Stelara is Non-Preferred for some plans; [^] A trial of more than one adalimumab product counts as ONE Preferred Product; SC – Subcutaneous; [*] A trial of more than one ustekinumab product counts as ONE Preferred Product.

POLICY STATEMENT

The program has been developed to encourage the use of the Preferred Products for Ulcerative Colitis. For all medications, this program requires the patient to meet the respective standard *Prior Authorization Policy* criteria. Additionally, this program requires trial(s) of the Preferred Product(s) according to the table above, when clinically appropriate, prior to the approval of the Non-Preferred Products. There are also situations when trials of Non-Preferred Products will be considered; see criteria below. Other details of the program are as follows:

- **Continuation of Therapy:** Approval for a patient continuing therapy with a **Non-Preferred** (subcutaneous or oral) Product must be supported with verification, noted in the criteria as either **[verification in prescription claims history required]** or, if not available, as **[verification by prescriber required]**.
  - If the patient has at least 130 days of prescription claims history on file, claims history must support that the patient has received the Non-Preferred Product for the specified period of time (90 or 120 days) within a 130-day look-back period; OR
  - When 130 days of the patient's prescription claim history file is unavailable for verification, the prescriber must verify that the patient has been receiving the Non-Preferred Product for a specified period of time (90 or 120 days), AND that the patient has been receiving the Non-Preferred Product via paid claims (e.g., patient has not been receiving samples or coupons or other types of waivers in order to obtain access to the Non-Preferred Product).

- For a patient continuing therapy, other conditions may also apply. Refer to criteria below.
- **Approval Duration:** All approvals for continuation of therapy for Preferred and Non-Preferred Products are provided for 1 year unless noted otherwise below. In cases where the initial approval is authorized in months, 1 month is equal to 30 days.

***Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy* non-preferred product(s) is(are) covered as medically necessary when the following non-preferred product exception criteria is(are) met. Any other exception is considered not medically necessary.**

NON-PREFERRED PRODUCT EXCEPTION CRITERIA

Non-Preferred Product	Exception Criteria
Zeposia	**1. <u>Multiple Sclerosis</u>.** Approve for 1 year if the patient meets the standard *Multiple Sclerosis and Ulcerative Colitis (Oral – Sphingosine 1-Phosphate Receptor Modulator) – Zeposia Prior Authorization Policy* criteria. **2. <u>Ulcerative Colitis – Initial Therapy</u>.** **A)** Approve for 6 months if the patient meets BOTH of the following (i <u>and</u> ii): **i.** Patient meets the standard *Multiple Sclerosis and Ulcerative Colitis (Oral – Sphingosine 1-Phosphate Receptor Modulator) – Zeposia Prior Authorization Policy* criteria; AND **ii.** Patient has tried TWO of an adalimumab product, Omvoh subcutaneous, Skyrizi subcutaneous, ustekinumab subcutaneous product, Tremfya subcutaneous, Velsipity, or Zymfentra. <u>Note</u>: Examples of adalimumab products include Humira, Abrilada, adalimumab-aacf, adalimumab-adaz, adalimumab-adbm, adalimumab-fkjp, adalimumab-aaty, adalimumab-ryvk, Simlandi, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Yuflyma, and Yusimry. Examples of ustekinumab products include Stelara/ustekinumab, Imuldosa, Wezlana, Otufli, Pyzchiva, ustekinumab-ttwe, Selarsdi, ustekinumab-aekn, Starjemza, Steqeyma, and Yesintek. A trial of an infliximab intravenous product (e.g., Remicade, biosimilars), Simponi subcutaneous, Entyvio intravenous or subcutaneous, Omvoh intravenous, Skyrizi intravenous, ustekinumab intravenous product, or Tremfya intravenous also counts. **B)** If the patient has met criterion 2Ai (the standard *Multiple Sclerosis and Ulcerative Colitis (Oral – Sphingosine 1-*

	Phosphate Receptor Modulator) – Zeposia Prior Authorization Policy criteria), but criterion 2Aii is not met, offer to review for a Preferred Product (adalimumab-adaz, adalimumab-adbm, Cyltezo, adalimumab-ryvk, Simlandi, Omvoh subcutaneous, Skyrizi subcutaneous (on-body injector), Stelara subcutaneous, Imuldosa subcutaneous, Selarsdi subcutaneous, ustekinumab-ttwe subcutaneous, Yesintek subcutaneous, Tremfya subcutaneous, Velsipity, or Zymfentra) using the respective standard *Inflammatory Conditions Prior Authorization Policy* criteria. **3. Ulcerative Colitis – Patient is Currently Receiving Zeposia.** **A)** Approve for 1 year if the patient meets BOTH of the following (i and ii): **i.** Patient meets the standard *Multiple Sclerosis and Ulcerative Colitis (Oral – Sphingosine 1-Phosphate Receptor Modulator) – Zeposia Prior Authorization Policy* criteria; AND **ii.** Patient meets ONE of the following conditions (a or b): **a)** Patient has tried TWO of an adalimumab product, Omvoh subcutaneous, Skyrizi subcutaneous, ustekinumab subcutaneous product, Tremfya subcutaneous, Velsipity, or Zymfentra; OR Note: Examples of adalimumab products include Humira, Abrilada, adalimumab-aacf, adalimumab-adaz, adalimumab-adbm, adalimumab-fkjp, adalimumab-aaty, adalimumab-ryvk, Simlandi, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Yuflyma, and Yusimry. Examples of ustekinumab products include Stelara/ustekinumab, Imuldosa, Wezlana, Otufli, Pyzchiva, ustekinumab-ttwe, Selarsdi, ustekinumab-aekn, Starjemza, Steqeyma, and Yesintek. A trial of an infliximab intravenous product (e.g., Remicade, biosimilars), Simponi subcutaneous, Entyvio intravenous or subcutaneous, Omvoh intravenous, Skyrizi intravenous, ustekinumab intravenous product, or Tremfya intravenous also counts. **b)** Patient has been established on Zeposia for at least 90 days and prescription claims history indicates at least a 90-day supply of Zeposia was dispensed within the past 130 days **[verification in prescription claims history required]** if claims history is not available, according to the prescriber **[verification by prescriber required]**. Note: In cases where 130 days of the patient's prescription claim history file is unavailable to be

	verified, an exception to this requirement is allowed if the prescriber has verified that the patient has been receiving Zeposia for at least 90 days AND the patient has been receiving Zeposia via paid claims (e.g., patient has not been receiving samples or coupons or other types of waivers in order to obtain access to Zeposia). **B)** If the patient has met criterion 3Ai (the standard *Multiple Sclerosis and Ulcerative Colitis (Oral – Sphingosine 1-Phosphate Receptor Modulator) – Zeposia Prior Authorization Policy* criteria), but criterion 3Aii is not met, offer to review for a Preferred Product (adalimumab-adaz, adalimumab-adbm, Cyltezo, adalimumab-ryvk, Simlandi, Omvoh subcutaneous, Skyrizi subcutaneous (on-body injector), Stelara subcutaneous, Imuldosa subcutaneous, Selarsdi subcutaneous, ustekinumab-ttwe subcutaneous, Yesintek subcutaneous, Tremfya subcutaneous, Velsipity, or Zymfentra) using the respective standard *Inflammatory Conditions Prior Authorization Policy* criteria.

REFERENCES

1. Zeposia® capsules [prescribing information]. Princeton, NJ: Celgene/Bristol Myers Squibb; August 2023.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	**Effective 01/01/2025.** A descriptor of Choice/Alternate was added to the policy name. **Ulcerative Colitis:** Humira (NDCs starting with 00074) and Hyrimoz (NDCs starting with 61314) were removed from the Preferred Products. Tremfya subcutaneous and Omvoh subcutaneous was added as Preferred Products. In the Note, it was added that previous trial of Tremfya intravenous also counts; since it is now Preferred, Omvoh subcutaneous was removed from the Note.	10/30/2024
Selected Revision	**Effective 01/01/2025** **Ulcerative Colitis:** Velsipity was added as a Preferred Product.	11/20/2024
Selected Revision	**Changes Effective 03/21/2025.** Throughout the policy, Stelara intravenous is referred to as ustekinumab intravenous. **Ulcerative Colitis:** Selarsdi, ustekinumab-ttwe, and Yesintek subcutaneous (SC) were added to the policy as Preferred ustekinumab SC products. Annotated that a trial of more than one ustekinumab SC product counts as one preferred product. Additionally, added examples of ustekinumab SC products in the Note.	03/12/2025
Selected Revision	Added a footnote to the table of Preferred and Non-preferred products that Stelara is non-preferred for some plans. Therefore, the *Inflammatory Conditions – Ustekinumab Subcutaneous*	06/04/2025

	Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies – Alternate or the *Choice* version of that policy should be referenced. Additionally, updated the Note regarding examples of ustekinumab subcutaneous products to include ustekinumab (unbranded Stelara), Imuldosa, ustekinumab-aekn, and Starjemza.	
Early Annual Revision	**Effective 10/01/2025.** **Ulcerative Colitis:** Imuldosa SC was added as a Preferred Ustekinumab product. Throughout the policy, the standard *Multiple Sclerosis and Ulcerative Colitis – Zeposia PA Policy* was changed to as listed.	09/10/2025