SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization may be delayed.**

Drug Requested: Eohilia™ (budesonide oral suspension)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Recommended Dosage: 2 mg orally twice daily (BID) for 12 weeks

Quantity Limit:

- 60 stick packs (1 carton) per 30 days
- Maximum QL is 180 stick packs (3 cartons) per 180 days

CLINICAL CRITERIA: Check below all that apply. **All criteria must be met for approval**. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ **Diagnosis: Eosinophilic Esophagitis (EoE)**

Initial Authorization: 3 months

❑ Prescribed by or in consultation with an allergist, immunologist, pulmonologist, or gastroenterologist

❑ Member is ≥ 11 years of age

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- ❑ Member has a documented diagnosis of EoE as evidenced by at least 15 intraepithelial eosinophils per high-powered microscopy field (eos/hpf), or 60 eosinophils/mm^2 on endoscopic biopsy **(chart notes must be submitted)**
- ❑ Member has a history of an average of at least two (2) episodes of dysphagia, with intake of solids, per week or prior history of esophageal dilation
- ❑ Provider attests to **ONE** of the following:
  - ❑ Member does **NOT** have a diagnosis of gastroesophageal reflux disease (GERD) and/or GERD diagnosis has been ruled out
  - ❑ Member has a diagnosis of GERD that is being adequately managed by high dose PPI therapy (e.g. omeprazole 40-80 mg daily)
- ❑ Provider attestation to other causes of esophageal eosinophilia have been ruled out (i.e. active helicobacter pylori infection, hypereosinophilic syndrome and eosinophilic granulomatosis with polyangiitis, Crohn's disease, ulcerative colitis, celiac disease, achalasia)
- ❑ Member meets **ONE** of the following:
  - ❑ Member has tried an elemental diet or an empiric, 6-food elimination diet (i.e., dairy, eggs, wheat, soy, peanuts, fish/shellfish) to treat/manage eosinophilic esophagitis
  - ❑ Provider has determined that the individual is **NOT** an appropriate candidate for dietary modifications **(clinical rationale must be documented in submitted chart notes)**
- ❑ Member has tried and failed swallowed topical glucocorticoids (e.g., nebulized or swallowed nasal drops such as budesonide nasal spray or nebulizer solution) for at least 6 -12 weeks within the past 90 days

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee: 5/23/2024**
REVISED/UPDATED/REFORMATTED: ~~5/8/2024~~; **7/31/2024**