CAREFIRST ASO
Eohilia

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Eohilia.

Patient Information

Patient Name:

Patient Phone: ☐☐☐-☐☐☐-☐☐☐☐

Patient ID:

Patient Group:

Patient DOB: ☐☐/☐☐/☐☐☐☐

Physician Information

Physician Name

Physician Phone: ☐☐☐-☐☐☐-☐☐☐☐

Physician Fax: ☐☐☐-☐☐☐-☐☐☐☐

Physician Addr.:

City, St, Zip:

Drug Name (select from list of drugs shown)

Eohilia Oral Suspension (budesonide)

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

_____

Please check the appropriate answer for each applicable question.

1.	Does the patient have the diagnosis of eosinophilic esophagitis (EoE)? ACTION REQUIRED: If yes, then prescriber MUST submit chart notes that support the patient's diagnostic findings of EoE (e.g., eosinophil-predominant inflammation on biopsy).	**Y** ☐	**N** ☐
2.	Have chart notes supporting the patient's diagnostic findings of eosinophilic esophagitis (EoE) (e.g., eosinophil-predominant inflammation on biopsy) been submitted to CVS Health? ACTION REQUIRED: Submit supporting documentation	**Y** ☐	**N** ☐
3.	Is the patient 11 years of age or older?	**Y** ☐	**N** ☐
4.	Is this request for continuation of therapy?	**Y** ☐	**N** ☐
5.	Has the patient achieved or maintained a positive clinical response (e.g., improvement in symptoms of esophageal dysfunction, histologic remission on biopsy)? ACTION REQUIRED: If yes, then prescriber MUST submit chart notes that support the patient's positive clinical response (e.g., improvement in symptoms of esophageal dysfunction, histologic remission on biopsy).	**Y** ☐	**N** ☐
6.	Have chart notes supporting the patient's positive clinical response (e.g., improvement in symptoms of esophageal dysfunction, histologic remission on biopsy) been submitted to CVS Health? ACTION REQUIRED: Submit supporting documentation	**Y** ☐	**N** ☐
7.	Does the patient require MORE than the plan allowance of 60 unit-dose packets per month?	**Y** ☐	**N** ☐

8. Does the patient have a history of clinical symptoms of esophageal dysfunction (e.g., eating problems, abdominal pain, heartburn, dysphagia, vomiting, food impaction, weight loss) at baseline? **Y** ☐ **N** ☐

9. Does the patient require MORE than the plan allowance of 60 unit-dose packets per month? **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date