PA Request Criteria

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CAREFIRST - MD EXCHANGE 5T
Corticosteroid-Pulmicort 1mg Post Limit (HMF)

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 855-582-2022 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Corticosteroid-Pulmicort 1mg Post Limit (HMF).

Patient Name: _____ **Date:** 11/28/2023
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**

Drug Name (select from list of drugs shown)
Budesonide 1mg/2mL Suspension

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)? **Y** ☐ **N** ☐
2. Is this request for continuation of therapy with Pulmicort (budesonide) Respules at a dose of 1mg twice daily (2mg daily)? **Y** ☐ **N** ☐
3. Has the patient been evaluated for improvement or relapse in symptoms or inflammation? **Y** ☐ **N** ☐
4. Has the patient had all of the following: A) Eosinophil-predominant inflammation on biopsy, B) Trial of a proton pump inhibitor (PPI), C) Secondary causes of esophageal eosinophilia were ruled out? **Y** ☐ **N** ☐
5. Does the patient require more than the plan allowance of 2 packages/60 respules 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

Effective July 1, 2015, Maryland law will require providers to submit pharmaceutical preauthorization requests electronically. To use ePA, either contact your electronic health record vendor or visit www.covermymeds.com/epa/caremark