BlueCross BlueShield Federal Employee Program

EOHILIA
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Eohilia

(budesonide)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Is this request for brand or generic? ❑Brand ❑Generic

2. Will the patient need more than 180 single-dose oral suspension stick packs for 12 weeks of therapy (1 cycle) per year? ❑Yes* ❑No
   If YES, please specify the requested quantity:_____ single-dose oral suspension stick packs for 12 weeks of therapy per year

3. Does the patient have a diagnosis of eosinophilic esophagitis (EoE)? ❑Yes ❑No

4. Does the prescriber agree to limit treatment to 12 weeks? ❑Yes ❑No

5. Does the patient have a level greater than or equal to 15 intraepithelial eosinophils per high-power field (eos/hpf)? ❑Yes ❑No

6. Is the patient showing symptoms of eosinophilic esophagitis such as dysphagia, heartburn, chest pain, or GERD-like symptoms? ❑Yes ❑No

7. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a proton pump inhibitor (PPI)? ❑Yes ❑No