PRIOR AUTHORIZATION CRITERIA

BRAND NAME (generic)

PULMICORT RESPULES 1MG ONLY (budesonide)

Status: CVS Caremark Criteria

Type: Post Limit Prior Authorization

FDA-APPROVED INDICATIONS

Pulmicort Respules is indicated for the maintenance treatment of asthma and as prophylactic therapy in children 12 months to 8 years of age.

Limitations of Use:

Pulmicort Respules is NOT indicated for the relief of acute bronchospasm.

Off-Label / Rare Disease / Orphan Drug Uses

Eosinophilic Esophagitis²⁻⁸

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

• The patient has the diagnosis of eosinophilic esophagitis (EoE)

AND

- The request is for continuation of therapy with Pulmicort (budesonide) Respules at a dose of 1mg twice daily (2mg daily), and the patient has been evaluated for improvement or relapse in symptoms or inflammation OR
- 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

Quantity Limits apply.

[120 mL (2 packages of 30 respules each) / 25 days*, or 360 mL (6 packages of 30 respules each) / 75 days*]
*The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing.

REFERENCES

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Corticosteroid Pulmicort 1mg Post Limit PA Policy 2495-J 10-2022

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- 9. Hirano I, Chan ES, Rank MA, et al. AGA institute and the joint task force on allergy-immunology practice parameters clinical guidelines for the management of eosinophilic esophagitis. *Gastroenterology*. 2020;158(6):1776-1786.