Prescriber Criteria Form

Budesonide 2024 PA Fax 4498-A v1 010124.docx
Entocort EC (budesonide delayed-release capsules), Ortikos (budesonide extended-release capsules)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**
Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Budesonide.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of Crohn's disease? [If no, then skip to question 5.]	Yes	No
2	Is the requested drug being prescribed for the treatment of mild to moderate active disease involving the ileum and/or the ascending colon? [If no, then skip to question 4.]	Yes	No
3	Is the patient 8 years of age or older? [No further questions.]	Yes	No
4	Is the requested drug being prescribed for the maintenance of clinical remission of mild to moderate disease involving the ileum and/or the ascending colon? [No further questions.]	Yes	No
5	Is the requested drug being prescribed for the induction of clinical remission of microscopic colitis in an adult patient? [If yes, then no further questions.]	Yes	No
6	Is the requested drug being prescribed for the maintenance of clinical remission of microscopic colitis in an adult patient? [If no, then no further questions.]	Yes	No

7	Has the patient had a recurrence of symptoms following discontinuation of induction therapy?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____