US FAMILY HEALTH PLAN
Prior Authorization Request Form for
budesonide oral suspension (Eohilia)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #:		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the requested medication being prescribed by a gastroenterologist or allergy/immunology specialist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have a documented diagnosis of Eosinophilic Esophagitis (EoE) by endoscopic biopsy?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Has the patient tried and had an inadequate response, intolerance, or contraindication to a Proton Pump Inhibitor?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Has the patient tried and had an inadequate response, intolerance, or contraindication to a formulary topical glucocorticoid that is not expected to occur with Eohilia? Note: an intolerance does not include preferences for flavor or taste of medication for pediatric patients.	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[17 April 2024]