

I. Requirements for Prior Authorization of Glucocorticoids, Oral

A. Prescriptions That Require Prior Authorization

Prescriptions for Glucocorticoids, Oral that meet any of the following conditions must be prior authorized:

1. A non-preferred Glucocorticoid, Oral. See the Preferred Drug List (PDL) for the list of preferred Glucocorticoids, Oral at: <https://papdl.com/preferred-drug-list>.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Glucocorticoid, Oral, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For a non-preferred Glucocorticoid, Oral, **all** of the following:
 - a. Is prescribed the Glucocorticoid, Oral for a diagnosis that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication,
 - b. Is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,
 - c. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Glucocorticoids, Oral approved or medically accepted for the beneficiary's diagnosis,
 - d. For a diagnosis of eosinophilic esophagitis, has a history of therapeutic failure of or a contraindication or an intolerance to inhaled fluticasone propionate,
 - e. For a diagnosis of primary immunoglobulin A nephropathy (IgAN), **all** of the following:
 - i. Has a diagnosis of primary IgAN that is confirmed by a kidney biopsy,
 - ii. Is prescribed the requested drug by or in consultation with a nephrologist,

- iii. Is at very high risk¹ for progressive disease or already has progressive disease despite at least three to six months of maximally tolerated doses of an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker based on current consensus guidelines,
- iv. Has an estimated glomerular filtration rate greater than or equal to 35 mL/min/1.73 m²;

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a Glucocorticoid, Oral. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

D. Dose and Duration of Therapy

Requests for prior authorization of Eohilia (budesonide oral suspension) and Tarpeyo (budesonide delayed-release capsules) will be approved for a dose and duration of therapy consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

¹In patients with IgAN, patients who present with three or more of the following features are considered to be at very high risk for progressive disease or to already have progressive disease:

- Persistent proteinuria ≥ 1 g/day on at least two separate tests.
- Persistent moderate microscopic hematuria/hemoglobinuria (arbitrarily defined as 1+ or greater on urine dipstick or >10 red blood cells [RBCs]/high-power field [hpf] on at least two separate tests, in the absence of another possible cause).
- Progressive decline in kidney function (eg, documented or inferred by an estimated glomerular filtration rate [eGFR] <60 mL/min/1.73 m² or a decrease in eGFR >3 mL/min/1.73 m² per year) considered to be due to active IgAN.
- Evidence of one or more active lesions on recent kidney biopsy (eg, Oxford classification M1, E1, or C1 or C2 scores [particularly crescents involving >10 percent of glomeruli]) or an S1 lesion with podocyte hypertrophy [6].

GLUCOCORTICOIDS, ORAL PRIOR AUTHORIZATION FORM *(form effective 1/5/2026)*

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	Total pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			NPI:	State license #:
LTC facility contact/phone:			Street address:	
Beneficiary name:			City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Drug requested:	Strength:	
Dose/directions:	Quantity:	Refills:
Diagnosis <i>(submit documentation)</i> :	Dx code <i>(required)</i> :	

Complete all sections that apply to the beneficiary and this request.

Check all that apply and submit documentation for each item.

<p>1. For a NON-PREFERRED Glucocorticoid, Oral:</p> <p><input type="checkbox"/> Tried and failed or has a contraindication or an intolerance to the preferred Glucocorticoids, Oral that are approved or medically accepted for the beneficiary's diagnosis <i>(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)</i></p>
<p>2. For treatment of EOSINOPHILIC ESOPHAGITIS (EOE):</p> <p><input type="checkbox"/> Tried and failed or has a contraindication or an intolerance to inhaled fluticasone propionate</p>
<p>3. For treatment of PRIMARY IMMUNOGLOBULIN A NEPHROPATHY (IgAN):</p> <p><input type="checkbox"/> Has a diagnosis of IgAN that is confirmed by a kidney biopsy</p> <p><input type="checkbox"/> Is prescribed the requested drug by or in consultation with a nephrologist</p> <p><input type="checkbox"/> Has 3 or more of the following features indicating the beneficiary is at very high risk for progressive disease or already has progressive disease despite at least 3 to 6 months of maximally tolerated doses of an ACE inhibitor or ARB based on current consensus guidelines:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Persistent proteinuria ≥ 1 g/day on at least 2 separate tests <input type="checkbox"/> Persistent moderate microscopic hematuria/hemoglobinuria (arbitrarily defined as 1+ or greater on urine dipstick or >10 RBCs/hpf on at least two separate tests, in the absence of another possible cause) <input type="checkbox"/> Progressive decline in kidney function (eg, documented or inferred by an eGFR 3 mL/min/1.73 m² per year) considered to be due to active IgAN <input type="checkbox"/> Evidence of one or more active lesions on recent kidney biopsy (eg, Oxford classification M1, E1, or C1 or C2 scores [particularly crescents involving >10 percent of glomeruli]) or an S1 lesion with podocyte hypertrophy <p><input type="checkbox"/> Has an eGFR ≥ 35 mL/min/1.73 m²</p>

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber Signature:	Date:
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