



Eohilia Prior Authorization with Quantity Limit Program Summary

POLICY REVIEW CYCLE

Effective Date
11-01-2025

Date of Origin
05-16-2024

POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Eohilia	budesonide oral suspension	2 MG/10ML	M ; N ; O ; Y	N		

POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
Eohilia	budesonide oral suspension	2 MG/10ML	1800	mLs	90	DAYS			

CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Eohilia	budesonide oral suspension	2 MG/10ML	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Eohilia	budesonide oral suspension	2 MG/10ML	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	<p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. The patient has a diagnosis of eosinophilic esophagitis (EoE) AND the patient's diagnosis has been confirmed by ALL of the following: <ol style="list-style-type: none"> A. Chronic symptoms of esophageal dysfunction AND B. Greater than or equal to 15 eosinophils per high-power field on esophageal biopsy AND C. Other causes that may be responsible for or contributing to symptoms and esophageal eosinophilia have been ruled out AND 2. The patient has ONE of the following: <ol style="list-style-type: none"> A. Has tried and had an inadequate response to ONE standard corticosteroid therapy (i.e., swallowed budesonide nebulizer suspension, swallowed fluticasone from a metered dose inhaler [MDI]) used in the treatment of EoE after at least an 8-week duration of therapy OR B. Has an intolerance or hypersensitivity to ONE standard corticosteroid therapy used in the treatment of EoE that is not expected to occur with the requested agent OR C. Has an FDA labeled contraindication to ALL standard corticosteroid therapies used in the treatment of EoE that is not expected to occur with the requested agent OR D. Has tried and had an inadequate response to ONE proton pump inhibitor (PPI) used in the treatment of EoE after at least an 8-week duration of therapy OR E. Has an intolerance or hypersensitivity to ONE PPI used in the treatment of EoE OR F. Has an FDA labeled contraindication to ALL PPIs used in the treatment of EoE AND 3. If the patient has an FDA labeled indication, then ONE of the following: <ol style="list-style-type: none"> A. The patient's age is within FDA labeling for the requested indication for the requested agent OR B. There is support for using the requested agent for the patient's age for the requested indication AND 4. The prescriber is a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, allergist, immunologist), or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND

Module	Clinical Criteria for Approval
	<p>5. The patient does NOT have any FDA labeled contraindications to the requested agent AND</p> <p>6. ONE of the following:</p> <ul style="list-style-type: none"> A. The patient has NOT previously been treated with a course of therapy (12 weeks) with the requested agent OR B. The patient has previously been treated with a course of therapy with the requested agent AND there is support for an additional course of therapy with the requested agent <p>Length of Approval:</p> <p>BCBSOK: 36 months BCBSIL, BCBSMT, and BCBSTX: 12 months ALL other plans: 3 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p> <p>The requested agent will also be approved when the following are met:</p> <ul style="list-style-type: none"> 1. The member resides in Ohio AND 2. The plan is Fully Insured or HIM Shop (SG) AND 3. The patient does NOT have any FDA labeled contraindications to the requested agent AND 4. ONE of the following: <ul style="list-style-type: none"> A. The patient has another FDA labeled indication for the requested agent and route of administration OR B. The patient has another indication that is supported in compendia for the requested agent and route of administration OR C. The prescriber has submitted TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] supporting the proposed use(s) as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required] <p>Non-oncology compendia allowed: DrugDex level 1, 2A or 2B, AHFS-DI (narrative text must be supportive)</p> <p>Oncology compendia allowed: NCCN 1 or 2A, AHFS-DI (narrative text must be supportive), DrugDex level 1, 2A, or 2B, or Clinical Pharmacology (narrative text must be supportive), Lexi-Drugs evidence level A, peer-reviewed medical literature</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria</p>

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	<p>Quantity Limit for the Target Agent(s) will be approved when ONE of the following is met:</p> <ul style="list-style-type: none"> 1. The requested quantity (dose) does NOT exceed the program quantity limit OR 2. The requested quantity (dose) exceeds the program quantity limit AND ONE of the following:

Module	Clinical Criteria for Approval
	<p>A. BOTH of the following:</p> <ol style="list-style-type: none"> 1. The requested agent does NOT have a maximum FDA labeled dose for the requested indication AND 2. There is support for therapy with a higher dose for the requested indication OR <p>B. BOTH of the following:</p> <ol style="list-style-type: none"> 1. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication AND 2. There is support for why the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does NOT exceed the program quantity limit OR <p>C. BOTH of the following:</p> <ol style="list-style-type: none"> 1. The requested quantity (dose) exceeds the maximum FDA labeled dose for the requested indication AND 2. There is support for therapy with a higher dose for the requested indication <p>Length of Approval:</p> <p>BCBSIL: 12 months</p> <p>All other plans: 3 months</p>