Clinical Policy: Budesonide (Eohilia, Uceris)

Reference Number: CP.PMN.294
Effective Date: 06.01.24
Last Review Date: 05.24
Line of Business: Commercial, HIM, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Budesonide (Eohilia™, Uceris®) is a glucocorticosteroid.

FDA Approved Indication(s)

Eohilia is indicated for 12 weeks of treatment in adult and pediatric patients 11 years of age and older with eosinophilic esophagitis (EoE) (oral suspension).

Uceris is indicated:

- For the induction of remission in adult patients with active, mild to moderate ulcerative colitis (UC) (extended-release tablet).
- For the induction of remission in patients with active mild to moderate distal UC extending up to 40 cm from the anal verge (rectal foam).

Limitation(s) of use: Eohilia has not been shown to be safe and effective for the treatment of EoE for longer than 12 weeks.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that budesonide extended-release tablet, budesonide rectal foam, Eohilia, and Uceris are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Ulcerative Colitis (must meet all)**:**

1. Diagnosis of UC;
2. Request is for generic budesonide extended-release tablet, generic budesonide rectal foam, or Uceris;
3. Prescribed by or in consultation with a gastroenterologist;
4. Age ≥ 18 years;
5. Failure of a 4-week trial of aminosalicylates (e.g., sulfasalazine, mesalamine; *see Appendix B*), unless clinically significant adverse effects are experienced or all are contraindicated;
6. Member must use generic budesonide tablet or rectal foam, unless contraindicated or clinically significant adverse effects are experienced;

7. Dose does not exceed one of the following (a or b):
   a. Oral: 9 mg (1 tablet) per day;
   b. Rectal:
      i. Initial: 2 canisters (1 kit) for 2 weeks;
      ii. Maintenance: 2 canisters (1 kit) every 4 weeks.

Approval duration: 12 months

B. Microscopic Colitis (off-label) (must meet all)**:**
1. Diagnosis of microscopic colitis, including collagenous colitis or lymphocytic colitis;
2. Prescribed by or in consultation with a gastroenterologist;
3. Age ≥ 18 years;
4. Request is for Uceris tablet or generic budesonide extended-release tablet;
5. Medical justification supports inability to use budesonide capsules;
6. Member must use generic budesonide tablet, unless contraindicated or clinically significant adverse effects are experienced;
7. Dose does not exceed 9 mg (1 tablet) per day.

Approval duration: 12 months

C. Eosinophilic Esophagitis (must meet all)**:**
1. Diagnosis of EoE confirmed be ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf) on endoscopic biopsy;
2. Prescribed by or in consultation with an allergist, immunologist, or gastroenterologist;
3. Age ≥ 11 years;
4. Request is for Eohilia oral suspension;
5. Member must use generic budesonide inhalation suspension, unless contraindicated or clinically significant adverse effects are experienced *(see Appendix D)*;
6. Dose does not exceed 4 mg (20 mL) per day.

Approval duration: 3 months

D. Other diagnoses/indications (meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Eosinophilic Esophagitis

1. Re-authorization is not permitted. Members must meet the initial approval criteria.

Approval duration: Not applicable

B. All Other Indications in Section I (must meet all)**:**

1. Request is for generic budesonide extended-release tablet, generic budesonide rectal foam, or Uceris;
2. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
3. Member is responding positively to therapy;
4. For microscopic colitis, request is for tablets;
5. Member must use generic budesonide tablet or rectal foam, unless contraindicated or clinically significant adverse effects are experienced;
6. Dose does not exceed one of the following (a or b):
   a. Oral: 9 mg (1 tablet) per day;
   b. Rectal: 2 canisters (1 kit) every 4 weeks.

Approval duration: 12 months

C. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies –

CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AGA: American Gastroenterological Association
EoE: eosinophilic esophagitis
eos: eosinophils
hpf: high-power field
FDA: Food and Drug Administration
UC: ulcerative colitis

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Ulcerative Colitis		
Pentasa® (mesalamine extended-release capsule)	1 g PO QID for up to 8 weeks or 500 mg PR BID to TID	4 g/day
mesalamine delayed-release capsule (Delzicol®)	800 mg PO TID for 6 weeks	2.4 g/day
mesalamine delayed-release tablet (Lialda®, Asacol® HD)	Lialda: 2.4 g to 4.8 g PO QD for up to 8 weeks Asacol HD: 1600 mg PO TID for 6 weeks	4.8 g/day
balsalazide (Colazal®, Giazo®)	2.25 g (capsule) PO TID for 8 to 12 weeks or 3.3 g (tablet) PO BID for up to 8 weeks	6.75 g/day
sulfasalazine (Azulfidine®, Azulfidine-EN tabs®)	Adults: Initial: 3 to 4 g/day (enteric coated) PO in evenly divided doses with dosage interval not exceeding 8 hours, or 1 g (uncoated) PO Q6-8 hrs Maintenance: 2 g/day (enteric coated) or 500 mg PO Q6H (uncoated) Children 6 years and older: 40 to 60 mg/kg of body weight/day PO divided into 3 to 6 doses	Adults: 4 g/day Children: 2 g/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): hypersensitivity to budesonide
- Boxed warning(s): none reported

Appendix D: General Information

- Per the 2016 American Gastroenterological Association (AGA) guidelines for microscopic colitis, budesonide 9 mg daily for 6 weeks is the preferred treatment option for microscopic colitis which includes lymphocytic colitis and collagenous colitis.
- Per the 2020 AGA guidelines for EoE, proton pump inhibitors, topical glucocorticosteroids, and dietary therapy are all considered as first-line therapies for EoE. The guideline supports the use of budesonide administered as an oral viscous slurry of budesonide inhalation suspension with sucralose or similar carrier vehicle.

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Budesonide (Uceris)	UC	Extended-release tablet: 9 mg PO daily in the morning for up to 8 weeks Rectal foam: 2 mg (1 metered dose) PR BID for 2 weeks, followed by 2 mg (1 metered dose) PR QD for 4 weeks	9 mg/day 4 canisters over 6 weeks
Budesonide (Eohilia)	EoE	2 mg PO BID for 12 weeks	4 mg/day up to 12 weeks total

VI. Product Availability

Drug Name	Availability
Budesonide (Uceris)	• Extended-release tablet: 9 mg • Rectal foam: 1 kit of 2 canisters (14 doses per canister, 2 mg per metered dose)
Budesonide (Eohilia)	Oral suspension: 2 mg/10 mL single-dose stick packs

VII. References

1. Uceris Extended Release Tablet Prescribing Information. Bridgewater, NJ: Salix Pharmaceuticals; April 2020. Available at: http://shared.salix.com/shared/pi/uceris-pi.pdf. Accessed June 28, 2023.
2. Uceris Rectal Foam Prescribing Information. Bridgewater, NJ: Salix Pharmaceuticals, Inc.; April 2020. Available at: https://www.bauschhealth.com/Portals/25/Pdf/PI/UCERIS-PI.pdf. Accessed June 28, 2023.
3. Eohilia Prescribing Information. Lexington, MA: Takeda Pharmaceuticals America; February 2024. Available at: www.eohilia.com. Accessed February 21, 2024.
4. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2019. Available at: http://www.clinicalpharmacology-ip.com/. Accessed July 10, 2023.

5. Rubin DT, Ananthakrishnan AN, Siegel CA, et al. American College of Gastroenterology (ACG) Clinical Guidelines; Ulcerative Colitis in Adults. Am J Gastroenterol 2019;114:384 – 413.
6. Ko CW, Singh S, Feuerstein JD, et al. American Gastroenterological Association (AGA) Clinical Practice Guidelines on the Management of Mild-to-Moderate Ulcerative Colitis. Gastroenterology 2019; 156(3):748-764.
7. Nguyen GC, Smalley WE, Vege SS, et al. American Gastroenterological Association institute guideline on medical management of microscopic colitis. Gastroenterology 2016; 150(1):242-246.
8. 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. Doi:10.1053/j.gastro.2020.02.038

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created (adapted from CP.PCH.11, which is to be retired): added budesonide extended-release tablet and budesonide rectal foam to Policy/Criteria section; added Medicaid line of business; for Commercial, revised approval duration from "12 months or duration of request, whichever is less" to the standard 12 months; RT4: added new dosage form Eohilia and corresponding criteria for EoE.	04.09.24	05.24

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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