RXADVANCE
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Clinical Policy Title:	budesonide
Policy Number:	RxA.286
Drug(s) Applied:	Uceris®, Entocort® EC, Ortikos
Original Policy Date:	02/07/2020
Last Review Date:	09/14/2020
Line of Business Policy Applies to:	All lines of business

Background

Uceris® is a glucocorticosteroid. It 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 adult patients with active mild to moderate distal UC extending up to 40 cm from the anal verge (rectal foam).

Entocort® EC is a corticosteroid. It is indicated:

- For treatment of mild to moderate active Crohn's disease involving the ileum and/or the ascending colon, in patients 8 years and older.
- For maintenance of clinical remission of mild to moderate Crohn's disease involving the ileum and/or the ascending colon for up to 3 months in adults.

Ortikos is a corticosteroid. It is indicated:

- For treatment of mild to moderate active Crohn's disease involving the ileum and/or the ascending colon, in patients 8 years and older.
- For maintenance of clinical remission of mild to moderate Crohn's disease involving the ileum and/or the ascending colon for up to 3 months in adults

Dosing Information

Drug Name	Indication	Dosing Regimen	Maximum Dose
Budesonide (Uceris®)	Ulcerative Colitis	Tablet, extended-release: 9 mg PO 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 once daily for 4 weeks	9 mg/day
Budesonide (Entocort® EC)	Mild to moderate active Crohn's disease	• For adults (Age≥ 18) 9 mg once daily for up to 8 weeks; repeat 8 week	9mg/day

		treatment courses recurring episodes of active disease • Pediatric patients (8 to 17 years) who weigh more than 25 kg: 9 mg once daily for up to 8 weeks, followed by 6 mg once daily in the morning for 2 weeks	
	Maintenance of clinical remission of mild to moderate Crohn's disease.	• Adults: 6 mg once daily for up to 3 months; taper to complete cessation after 3 months. Continued treatment for more than 3 months has not been shown to provide substantial clinical benefit.	6 mg/day
Budesonide (Ortikos)	Mild to moderate active Crohn's disease	• For adults (Age≥ 18) 9 mg once daily for up to 8 weeks; repeat 8 week treatment courses recurring episodes of active disease • Pediatric patients (8 to 17 years) who weigh more than 25 kg: 9 mg once daily for up to 8 weeks, followed by 6 mg once daily in the morning for 2 weeks	9mg/day
	Maintenance of clinical remission of mild to moderate Crohn's disease	• Adults: 6 mg once daily for up to 3 months; taper to complete cessation after 3 months. Continued treatment for more than 3 months has not been shown to provide substantial clinical benefit.	6 mg/day

Dosage Forms

Uceris®

- Tablets, extended-release: 9 mg
- Rectal foam: 1 kit of 2 canisters (14 doses per canister, 2 mg per metered dose)

Entocort® EC

- Delayed-Release Capsules: 3 mg

Ortikos

- Extended-Release Capsules: 6 mg and 9 mg

Clinical Policy

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

I. Initial Approval Criteria

A. Ulcerative Colitis (must meet all):

1. Diagnosis of Ulcerative Colitis (UC);
2. Prescribed by or in consultation with a gastroenterologist;
3. Age ≥ 18 years;
4. Failure of a 4-week trial of aminosalicylates (e.g., sulfasalazine, mesalamine; Appendix B), unless contraindicated or clinically significant adverse effects are experienced;
5. 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 for 2 weeks;
      II. Maintenance: 2 canisters every 4 weeks.

Approval Duration
Commercial: 12 months
Medicaid: 12 months
HIM: 6 months for rectal foam

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 GI specialist
3. Age ≥ 18 years;
4. Request is for tablets;
5. Medical justification supports inability to use budesonide capsules;
6. Dose does not exceed 9 mg (1 tablet) per day

Approval Duration
Commercial: 12 months
Medicaid: 12 months

C. Crohn's disease (must meet all):

1. Diagnosis of Crohn's disease
2. Prescribed by or in consultation with a GI specialist
3. Age ≥ 8 years;
4. Request is for Ortikos or Entocort EC;

5. Medical justification supports inability to use budesonide tablets;
6. Dosing does not exceed (a or b):
    a. For Ortikos
        i. Initial: Dose does not exceed 9 mg (1 capsule) per day;
        ii. Maintenance: Dose does not exceed 6 mg (1 capsule) per day
    b. For Entocort EC
        i. Initial: Dose does not exceed 9 mg (3 capsule) per day;
        ii. Maintenance: Dose does not exceed 6 mg (2 capsule) per day.

Approval Duration
Commercial: 12 months
Medicaid: 12 months

II. Continued Therapy Approval

A. All Indications in Section I (must meet all):

1. Currently receiving medication that has been authorized by RxAdvance or member has previously met initial approval criteria listed in this policy;
2. Member is responding positively to therapy;
3. For microscopic colitis, request is for tablets;
4. For UC or microscopic colitis: Dose does not exceed one of the following:
    i. If request is for Uceris:
        a) Oral: 9 mg (1 tablet) per day;
        b) Rectal: 2 canisters every 4 weeks.
5. For CD: Dose does not exceed one of the following:
    i. If request is for Ortikos:
        a) Initial: Dose does not exceed 9 mg (1 capsule) per day;
        b) Maintenance: Dose does not exceed 6 mg (1 capsule) per day
    ii. If request is for Entocort EC:
        a) Initial: Dose does not exceed 9 (3 capsule) mg per day;
        b) Maintenance: Dose does not exceed 6 mg (2 capsule) per day.

Approval Duration
Commercial: 12 months
Medicaid: 12 months
HIM: 6 months for rectal foam

III. Appendices

APPENDIX A: Abbreviation/Acronym Key
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
Pentasa® (mesalamine extended-release capsule)	**UC** 1 g PO QID for up to 8 weeks or 500 mg PR BID to TID	4 g/day
	CD 1,000 mg PO QID	4 mg per day
Delzicol® (mesalamine delayed-release capsule)	**UC** 800 mg PO TID for 6 weeks	2.4 g/day
mesalamine delayed-release tablet (Lialda®, Asacol® HD)	**UC** Lialda: 2.4 g to 4.8 g PO once daily for up to 8 weeks Asacol HD: 1600 mg PO TID for 6 weeks	4.8 g/day
balsalazide (Colazal®, Giazo®)	**UC** 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®)	**UC** <u>Adults:</u> 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) <u>Children 6 years and older:</u> 40 to 60 mg/kg of body weight/day PO divided into 3 to 6 doses	Adults: 4 g/day Children: 2 g/day
6-mercaptopurine (Purixan®)	**CD** 50 mg PO QD or 1 – 2 mg/kg/day PO 2 mg/kg/day	2 mg/kg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Rheumatrex®(methotrexate)	**CD** 15 – 25 mg/week IM or SC	30 mg/week
Prograf® (Tacrolimus)	**CD** 0.27 mg/kg/day PO in divided doses or 0.15 – 0.29 mg/kg/day PO	N/A

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 or any of the ingredients in Uceris (tablets or rectal foam) or Ortikos Or Entocort EC.

- Boxed Warning(s):
  - None reported

APPENDIX D: General Information

- Per the 2016 American Gastroenterological Association guidelines, budesonide 9 mg daily for 6 weeks is the preferred treatment option for microscopic colitis which includes lymphocytic colitis and collagenous colitis.
- Avoid consumption of grapefruit juice for the duration of therapy with Ortikos or Entocort® EC.

References

1. Uceris Extended Release Tablet Prescribing Information. Bridgewater, NJ: Salix Pharmaceuticals; April 2020. Available at: http://shared.salix.com/shared/pi/ucerispi.pdf . Accessed August 25, 2020.
2. Uceris Rectal Foam Prescribing Information. Bridgewater, NJ: Salix Pharmaceuticals, Inc.; April 2020. Available at: https://www.bauschhealth.com/Portals/25/Pdf/PI/UCERISPI.pdf. Accessed August 25, 2020.
3. Entocort® EC Capsule Prescribing information. Allegan, MI: Perrigo Pharma International DAC; July 2020. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2020/021324s023lbl.pdf. Accessed August 26, 2020
4. Ortikos Capsule Prescribing information. Cranbury, NJ: Sun Pharmaceutical Industries, Inc; June 2019. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/211929s000lbl.pdf. Accessed August 26,
5. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2019. Available at: http://www.clinicalpharmacology-ip.com/. Accessed August 25, 2020.
6. 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.
7. 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.
8. 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.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	01/2020	02/07/2020
Policy was reviewed: 1. Clinical policy title updated 2. Line of Business Policy Applies to was updated to all lines of business. 3. Added alternative authorized brand (Entocort® EC, Ortikos) and indication for both brand 4. Initial approval criteria I.B.4- one criteria added. 5. Continued Therapy criteria II.A.1 was rephrased to "Currently receiving medication that has been authorized by RxAdvance..." 6. Reference reviewed and updated	08/25/2020	09/14/2020