Clinical Policy: Glucocorticoids, Oral

Reference Number: PHW.PDL.168
Effective Date: 01/01/2020
Last Review Date: 11/2025

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 PA Health & Wellness® that Oral Glucocorticoids are **medically necessary** when the following criteria are met:

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 Glucocorticoids, Oral.

B. 2. A Glucocorticoid, Oral with a prescribed quantity that exceeds the quantity limit.Clinical Review Guidelines and Review of Documentation for Medical Necessity

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

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 member'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 risk[1] 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 m^2;

OR

2. If a prescription for a Glucocorticoid, Oral is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

NOTE: If the member 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 member, 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 the request for 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 member.

D. **Approval Duration:**

[1] In 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].

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.

All other drugs: duration of request or 12 months (whichever is less)

E. **References**:

1. Bonis PA, Gupta SK. Treatment of eosinophilic esophagitis (EoE). In: UpToDate [internet database]. Talley NJ, Meyer C, eds. Waltham, MA: UpToDate Inc. Updated June 5,2025. Accessed July 31, 2025.
2. Dellon ES, Muir AB, Katzka DA, et al. ACG Clinical Guideline: Diagnosis and Management of Eosinophilic Esophagitis. The American Journal of Gastroenterology 120(1):p 31-59, January 2025.
3. Cattran DC, Appel GB, Coppo R. IgA nephropathy: Treatment and prognosis. In: UpToDate [internet database]. Glassock RJ, Fervenza FC, eds. Waltham, MA: UpToDate Inc. Updated September 19, 2025. Accessed October 8, 2025.
4. Kidney Disease: Improving Global Outcomes (KDIGO) ADPKD Work Group. KDIGO 2025 Clinical Practice Guideline for the Management of Immunoglobulin A Nephropathy (IgAN) and Immunoglobulin A Vasculitis (IgAV). Kidney Int. 2025;108(4S):S1–S71.

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021 annual review: no changes.	01/2021
Q1 2023: policy revised according to DHS revisions effective 01/09/2023.	10/2022
Q1 2024 annual review: no changes.	11/2023
Q1 2025 annual review: no changes.	11/2024
Q1 2026: policy revised according to DHS revisions effective 01/05/2026.	11/2025