Prescriber Criteria Form Uceris 2025 PA Fax 4500-A v1 010125.docx Uceris (budesonide tablets) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Uceris (budesonide tablets).

Drug Name: Uceris (budesonide tablets)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for the induction of remission in a patient with active, mild to moderate ulcerative colitis? [If no, then no further questions.]	Yes ◯	No ◯
2	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to at least one 5-aminosalicylic acid (5-ASA) therapy?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ **Date:**_____