Original Effective Date: 08/24/2016
Current Effective Date: 12/01/2025
Last P&T Approval/Version: 10/29/2025
Next Review Due By: 10/2026
Policy Number: C4724-A

Pulmicort Respules (budesonide)

PRODUCTS AFFECTED

Pulmicort respules (budesonide inhalation suspension), budesonide inhalation susp

COVERAGE POLICY

Coverage for services, procedures, medical devices, and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any. This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines.

Documentation Requirements:
Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

DIAGNOSIS:
Chronic asthma, Eosinophilic esophagitis, Chronic obstructive pulmonary disease (COPD)

REQUIRED MEDICAL INFORMATION:
This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by-case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review. When the requested drug product for coverage is dosed by weight, body surface area or other member specific measurement, this data element is required as part of the medical necessity review. The Pharmacy and Therapeutics Committee has determined that the drug benefit shall be a mandatory generic and that generic drugs will be dispensed whenever available.

A. CHRONIC ASTHMA:
   1. Documented diagnosis of chronic asthma
      AND
   2. (a) Member is 8 years of age or YOUNGER

OR
(b) Member is not able to use an oral aerosol inhaler device

B. EOSINOPHILIC ESOPHAGITIS:
1. Documented diagnosis of eosinophilic esophagitis
AND
2. Documentation of inadequate response, serious side effects, or clinical contraindication to one formulary/preferred proton pump inhibitor OR proton pump inhibitor will be used concurrently

C. CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD):
1. Documented diagnosis of chronic obstructive pulmonary disease (COPD)
AND
2. Member will not be using budesonide as monotherapy
AND
3. Member has severe exacerbations (defined as requiring hospitalization or ED visit and may also be associated with acute respiratory failure) in which nebulized medication is required rather than MDI dosage form

CONTINUATION OF THERAPY:
A. FOR ALL INDICATIONS:
1. Adherence to therapy at least 85% of the time as verified by the prescriber or member's medication fill history OR adherence less than 85% of the time due to the need for surgery or treatment of an infection, causing temporary discontinuation
AND
2. Prescriber attests to or clinical reviewer has found no evidence of intolerable adverse effects or drug toxicity
AND
3. Documentation of stabilization or improvement in clinical signs and symptoms of disease state

DURATION OF APPROVAL:
Initial authorization: 12 months, Continuation of Therapy: 12 months

PRESCRIBER REQUIREMENTS:
No requirements

AGE RESTRICTIONS:
Asthma:12 months of age and older
All other indications: no restriction

QUANTITY:
Asthma: maximum 1 mg/day
COPD: maximum 2 mg/day
Eosinophilic esophagitis: Oral induction: 2 mg/day as an oral budesonide viscous liquid/suspension; Maintenance therapy: 0.5 to 1 mg/day

PLACE OF ADMINISTRATION:
The recommendation is that inhalation medications in this policy will be for pharmacy benefit coverage and patient self-administered.

DRUG INFORMATION

ROUTE OF ADMINISTRATION:
Inhalation via Nebulizer
Off-Label: Compounded as an oral budesonide viscous liquid/suspension

DRUG CLASS:
Steroid Inhalants

FDA-APPROVED USES:
Indicated for the maintenance treatment of asthma and as prophylactic therapy in children 12 months to 8 years of age
Limitations of use: Not indicated for the relief of acute bronchospasm

COMPENDIAL APPROVED OFF-LABELED USES:
Eosinophilic esophagitis, Chronic obstructive pulmonary disease (acute exacerbation), Chronic obstructive pulmonary disease (stable)

APPENDIX

APPENDIX:
None

BACKGROUND AND OTHER CONSIDERATIONS

BACKGROUND:
For the treatment of laryngotracheobronchitis (croup)
Budesonide efficacy has been demonstrated in several studies. Most studies have shown comparable efficacy outcomes with dexamethasone for the treatment of croup; however, some studies have shown dexamethasone to be superior to budesonide. The addition of budesonide to dexamethasone therapy has not resulted in an additive benefit in clinical studies.

CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:
All other uses of Pulmicort respules (budesonide inhalation suspension) are considered experimental/investigational and therefore, will follow Molina's Off-Label policy. Contraindication to Pulmicort respules (budesonide inhalation suspension) include: primary treatment of status asthmaticus or other acute episodes of asthma where intensive measures are requires, hypersensitivity to budesonide or any of the ingredients of the respule.

OTHER SPECIAL CONSIDERATIONS:
Viscous budesonide for eosinophilic esophagitis can be compounded by mixing two or four 0.5 mg/2 mL Pulmicort Respules with sucralose (Splenda; 10 1-gram packets per 1 mg of budesonide, creating a volume of approximately 8 mL) or another carrier vehicle that is not liquid.

CODING/BILLING INFORMATION

CODING DISCLAIMER. *Codes listed in this policy are for reference purposes only and may not be all-inclusive or applicable for every state or line of business. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry-standard coding practices for all submissions. Molina has the right to reject/deny the claim and recover claim payment(s) if it is determined it is not billed appropriately or not a covered benefit. Molina reserves the right to revise this policy as needed.*

HCPCS CODE	DESCRIPTION
N/A	N/A

AVAILABLE DOSAGE FORMS:
Budesonide SUSP 0.25MG/2ML, 0.5MG/2ML, 1MG/2ML
Pulmicort SUSP 0.25MG/2ML, 0.5MG/2ML, 1MG/2ML

REFERENCES

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SUMMARY OF REVIEW/REVISIONS	DATE
REVISION- Notable revisions: Required Medical Information Age Restrictions References	Q4 2025

REVISION- Notable revisions: Coding/Billing Information Template Update Required Medical Information References	Q4 2024
REVISION- Notable revisions: Diagnosis Required Medical Information FDA-Approved Uses Contraindications/Exclusions/Discontinuation Other Special Considerations	Q4 2023

REVISION- Notable revisions: Products Affected Required Medical Information Continuation of Therapy Age Restrictions Quantity Other Special Considerations References	Q4 2022
Q2 2022 Established tracking in new format	Historical changes on file