SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Strensiq® (asfotase alfa)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

For 6 month initial authorization, all of the following criteria must be met

- ❑ Prescribed by or in consultation with a specialist in the area of the member's diagnosis (e.g., endocrinologist, geneticist)
- ❑ Member has a diagnosis of either perinatal/infantile- or juvenile-onset hypophosphatasia (HPP) AND **ALL** of the following:

(Continued on next page)

- ❑ Member was less than 18 years of age at onset
  - ❑ Member has/had clinical manifestations consistent with hypophosphatasia at the age of onset prior to age 18 (e.g., vitamin B6-dependent seizures, fractures, lost teeth with roots, skeletal abnormalities: such as rachitic chest deformity leading to respiratory problems or bowed arms/legs, "failure to thrive")
  - ❑ Member has/had radiographic imaging confirming the diagnosis of hypophosphatasia at the age of onset prior to age 18 (e.g., infantile rickets, alveolar bone loss, craniosynostosis)
- ❑ Member is experiencing active disease (e.g., bone pain, fractures, gait problems)
- ❑ Molecular genetic testing has been completed confirming mutations in the ALPL gene that encodes the tissue nonspecific isoenzyme of ALP (TNSALP)
- ❑ The member has reduced activity of unfractionated serum alkaline phosphatase (ALP) in the absence of bisphosphonate therapy (i.e., below the normal lab reference range for age and sex)
- ❑ One of the following:
  - ❑ Elevated serum concentration of pyridoxal 5'-phosphate (PLP) in the absence of vitamin supplements within one week prior to the test
  - ❑ Elevated urine concentration of phosphoethanolamine (PEA)
  - ❑ Elevated urinary inorganic pyrophosphate (PPi)

For 12 month re-authorization, all of the following criteria must be met. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member continues to meet all of the initial criteria
- ❑ Member continues to experience clinical benefit from the requested treatment

Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

***Approved by Pharmacy and Therapeutics Committee**: 6/20/2019
REVISED/UPDATED/REFORMATTED: ~~8/13/2019; 9/26/2023;~~ **7/1/2026**