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: Sucraid® (sacrosidase)

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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight: _____ **Date:** _____

Quantity Limit: 236mL/30 days

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.

Initial Approval: 60 days

- ❑ Patient is 5 months of age or older and has a diagnosis of congenital sucrase-isomaltase deficiency (CSID) confirmed by a gastroenterologist, endocrinologist, or genetics specialist

AND

(Continued on next page)

- ❑ Patient has documented chronic symptoms of CSID including watery diarrhea, abdominal pain, gas/bloating after sucrose/starch ingestion (must submit chart notes documenting symptoms following sucrose/starch ingestion)
  - Number of severe GI events within the last 2 months: _____ **(must be documented in submitted chart notes)**

AND

- ❑ A low sucrose and low starch diet has been attempted with improvement in patient symptoms, and patient will continue to follow a low sucrose, low starch diet while on therapy

AND

- ❑ Patient does not have lactose intolerance or a secondary sucrase deficiency associated with any of the following: celiac disease, Crohn's disease, autoimmune gastroenteropathy, eosinophilic gastroenteropathy, short bowel syndrome, Giardiasis, small intestinal bacterial overgrowth (SIBO), acute gastroenteritis, or enteropathy associated with acquired immune deficiency syndrome

AND (ALL 4 below MUST be met):

❑ Stool pH < 6.0	❑ Increase in breath hydrogen of > 10 ppm when challenged with sucrose after fasting
❑ Genetic test results confirm diagnosis of CSID	❑ Negative lactose breath test

OR (BOTH below MUST be met)

- ❑ Small bowel biopsy documents intestinal sucrase activity of <25 U/g protein (must be greater than 2 standard deviations below the mean) with normal or decreased maltase and isomaltase levels, normal levels of other disaccharides, and normal villous architecture of the small intestine on biopsy
- ❑ Genetic testing results document sucrase-isomaltase deficiency (CSID)

Reauthorization Approval: 12 months. 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.

- ❑ Patient has had a 50% reduction in all symptoms of CSID, including watery diarrhea, abdominal pain, gas/bloating; etc. **(improvement from baseline must be noted in submitted chart notes)**
  - Number of severe GI events within the last 2 months: _____ **(must be documented in submitted chart notes)**

AND

- ❑ Patient will continue to follow a low sucrose, low starch diet while on therapy

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.*