Updated: 06/2024
PARP Approved: 07//2024

Prior Authorization Criteria

Sucraid (sacrosidase)

All requests for Sucraid (sacrosidase) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Coverage may be provided with a diagnosis of genetically determined sucrase deficiency, part of CSID, and the following criteria is met:

- Must be age 5 months or older
- Must have a diagnosis of congenital sucrase-isomaltase deficiency (CSID) confirmed by **ONE** of the following:
    - Genetic testing of the sucrase-isomaltase (SI) gene indicative of a pathogenic mutation
    - Small bowel biopsy indicating decreased or absent sucrase activity, isomaltase activity varying from decreased to normal activity and decreased maltase activity
    - Meeting all of the following criteria:
        - Stool pH< 6
        - Increase in breath hydrogen of >10ppm when challenged with sucrose after fasting
        - Negative lactose breath test
- Must be prescribed by or in consultation with a pediatric gastroenterologist or genetic specialist
- The member does not have any FDA labeled contraindications to the requested medication
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
    - Prescribed by or in consultation with a pediatric gastroenterologist or genetic specialist
    - Provider attests the member achieved a clinically meaningful response while on therapy, defined as at least a 50% reduction in all of the following:
        - Symptoms of abdominal pain, cramps, bloating, gas, vomiting
        - Number of stools per day
        - Number of Symptomatic days
        - Stool consistency is watery and loose

Reauthorization Duration of Approval: 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

HIGHMARK WHOLECARE

Updated: 06/2024
PARP Approved: 07//2024

SUCRAID (SACROSIDASE)
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Wholecare Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (800) 392-1147 Mon – Fri 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	Provider NPI:
Provider Specialty:	Office Contact:
State license #:	Office NPI:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: Genetically determined sucrase deficiency, part of CSID ; Other_____ ICD Code:

Has the diagnosis been confirmed by **one** of the following:

☐ Genetic testing of the sucrase-isomaltase (SI) gene indicative of a pathogenic mutation

☐ Small bowel biopsy indicating decreased or absent sucrase activity, isomaltase activity varying from decreased to normal activity and decreased maltase activity

☐ **ALL** of the following: Stool pH< 6, increase in breath hydrogen of >10ppm when challenged with sucrose after fasting AND negative lactose breath test

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member achieved a clinically meaningful response while on therapy, defined as at least a 50% reduction in all of the following:

☐ Symptoms of abdominal pain, cramps, bloating, gas, vomiting

☐ Number of stools per day

☐ Number of Symptomatic days

☐ Stool consistency is watery and loose

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date