HIGHMARK WHOLECARE

Updated: 09/2026
PARP Approved: 09/01/2026

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 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
    - An abnormal carbon-13 sucrose breath test
    - 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.

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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

☐ An abnormal carbon-13 sucrose breath test

☐ 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