OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(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. **Incomplete form will delay authorization process**.

Drug Requested: **Sucraid®** (sacrosidase)

DRUG INFORMATION: Complete information below or authorization process will be delayed.

Drug Form/Strength: _____

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

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

Quantity Limit: 1 box per month

CLINICAL CRITERIA: **ALL** boxes below **must** be checked to qualify to ensure authorization will **NOT** be delayed.

- ❑ Patient has a documented diagnosis of congenital sucrase- isomaltase deficiency by a gastroenterologist, endocrinologist, or genetic specialist

AND (ALL 4 below MUST be met):

❑ Positive Stool pH < 6.0	❑ Positive breath test: an increase in breath Hydrogen of > 10 ppm when challenged with sucrose after fasting
❑ SI Genetic Test	❑ Negative lactose breath test

OR (Both below MUST be met)

- ❑ Positive measurement of intestinal disaccharidases upon small bowel biopsy
- ❑ SI Genetic Test

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.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***REVISED/UPDATED:** ~~8/27/2017;~~ **8/30/2018**