OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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. If incomplete, 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 or authorization process will 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**