

OPTIMA HEALTH PLAN

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. 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):

<input type="checkbox"/> Positive Stool pH < 6.0	<input type="checkbox"/> Positive breath test: an increase in breath Hydrogen of > 10 ppm when challenged with sucrose after fasting
<input type="checkbox"/> SI Genetic Test	<input type="checkbox"/> 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 #: _____

*Approved by Pharmacy and Therapeutics Committee: 1/15/2015

REVISED/UPDATED: 4/26/2015; 5/22/2015; 12/29/2015; 12/20/2016; 9/23/2017