OPTUMRx®

Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Optima Health®

Sucraid® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand** ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Congenital sucrase-isomaltase deficiency

❑ Other diagnosis: ____________________________ ICD-10 Code(s): ____________________________

Clinical information:

Was the patient diagnosed with congenital sucrase-isomaltase deficiency by a gastroenterologist, endocrinologist, or genetic specialist? ❑ **Yes** ❑ **No**

Select if the patient meets the following:

❑ Positive stool pH less than 6.0

❑ Positive breath test (an increase in breath Hydrogen of greater than 10 ppm when challenged with sucrose after fasting)

❑ Negative lactose breath test

❑ SI genetic test

❑ Positive measurement of intestinal disaccharidases upon small bowel biopsy

Quantity limit requests:

What is the quantity requested per MONTH? ________

Previous therapies failed and/or therapies currently used in combination with the requested medication (*List ALL medications tried or authorization process will be delayed)*:____

____

____

Is the prescribed dose higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert)? ❑ **Yes** ❑ **No**

If **Yes**, please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature).

*** Please note: Chart documentation of the above is required to be submitted along with this fax*

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****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.

Prescriber Signature:_________________________ **Date:** ______________________________

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

____

____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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