PARAMOUNT
Affiliate of ProMedica

Criteria: PMT
Approved: 11/2014
Verified: 12/2019
Reviewed:

Prior Authorization Criteria Form

This form applies to Paramount Commercial Members Only

Sucraid

Complete/review information, sign and date. Please fax signed forms to Paramount at **1-844-256-2025**. You may contact Paramount by phone at **1-419-887-2520** with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Sucraid.

Drug Name (select from list of drugs shown)

Other, Please specify Sucraid (sacrosidase)

Quantity _____ **Frequency** _____ **Strength** _____

Route of Administration _____ **Expected Length of Therapy** _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is the request being prescribed by or in conjunction with a gastroenterologist, endocrinologist, or genetic specialist? Y N
   [If no, then no further questions.]
2. Is the request being prescribed in conjunction with non-pharmacological therapies (i.e., dietary restriction of starch)? Y N
   [If no, then no further questions.]
3. Is the request for continuation of therapy? Y N
   [If no, then skip to question 5.]
4. Is there evidence of clinical benefit through improvement of symptoms? Y N
   [No further questions.] Y N
5. Does the patient have clinically documented congenital sucrase-isomaltase deficiency (CSID) diagnosed by a board certified gastroenterologist, endocrinologist, or genetic specialist?

[If no, then no further questions.]

6. Does the patient have a positive stool pH (pH less than 6.0)? Y N
   [If no, then no further questions.]
7. Does the patient have a positive breath hydrogen analysis (less than 20ppm H2 over baseline) OR a small bowel biopsy documenting greater than 2 standard deviations below mean for sucrase activity with or without isomaltase activity with normal lactase activity and normal villous architecture? Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date