STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

SACROSIDASE

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
SACROSIDASE	SUCRAID	18554		GPI-10 (5120006000)	

GUIDELINES FOR USE

INITIAL CRITERIA (NOTE: FOR RENEWAL CRITERIA SEE BELOW)

1. Does the patient have a diagnosis of genetically determined sucrase deficiency, which is part of congenital sucrase-isomaltase deficiency (CSID), and meet **ALL** of the following criteria?
   - Therapy is prescribed by or in consultation with a gastroenterologist or medical geneticist
   - The patient's diagnosis is confirmed by ONE of the following:
     - Small bowel biopsy
     - Sucrose breath test
     - Genetic test

   If yes, **approve for 12 months by HICL or GPI-10.**
   If no, do not approve.
   INITIAL DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

   Our guideline named **SACROSIDASE (Sucraid)** requires the following rule be met for approval:
   A. You have a genetically determined sucrase deficiency , which is part of congenital sucrase-isomaltase deficiency (a type of genetic digestive condition)
   B. Therapy is prescribed by or in consultation with a gastroenterologist (doctor who treats digestive conditions) or medical geneticist (doctor who treats gene disorders)
   C. Your diagnosis is confirmed by ONE of the following:
      1. Small bowel biopsy (removal of cells or tissue from the body for examination)
      2. Sucrose breath test
      3. Genetic test

   Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

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SACROSIDASE

GUIDELINES FOR USE (CONTINUED)

RENEWAL CRITERIA

1. Does the patient have a diagnosis of genetically determined sucrase deficiency, which is part of congenital sucrase-isomaltase deficiency (CSID) **AND** meet the following criterion?
   - The patient has experienced or maintained improvement on treatment

     If yes, **approve for 12 months by HICL or GPI-10.**
     If no, do not approve.
     RENEWAL DENIAL TEXT: ***Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.**

     Our guideline named **SACROSIDASE (Sucraid)** requires the following rule(s) be met for renewal:
     A. You have a genetically determined sucrase deficiency which is part of congenital sucrase-isomaltase deficiency (a type of genetic digestive condition)
     B. You have experienced or maintained improvement on treatment

     Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RATIONALE
For further information, please refer to the Prescribing Information and/or Drug Monograph for Sucraid.

REFERENCES

- Sucraid [Prescriber Information]. Vero Beach, FL: QOL Medical, LLC.; August 2021.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 07/01/22
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