

# STRENSIQ

## PRIOR AUTHORIZATION REQUEST

### PRESCRIBER FAX FORM

**Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.**

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit [www.myprime.com](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermymeds.com](http://covermymeds.com) to begin using this free service.

**What is the priority level of this request?**

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

**Today's Date:** \_\_\_\_\_

**PATIENT AND INSURANCE INFORMATION**

**Date of Service (if differs from Today's Date):** \_\_\_\_\_

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

**PRESCRIBER/CLINIC INFORMATION**

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

Patient's Diagnosis:

- Perinatal/infantile-onset hypophosphatasia (HPP)
- Juvenile-onset hypophosphatasia (HPP)
- Other (ICD code plus description): \_\_\_\_\_

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

**For all requests:**

1. What is the patient's weight? \_\_\_\_\_ (kg)
2. Is the patient currently being treated with the requested agent? .....  Yes  No
3. Does the patient have any FDA labeled contraindications to the requested agent? .....  Yes  No  
 If yes, please specify contraindications: \_\_\_\_\_  
 \_\_\_\_\_
4. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., endocrinologist, geneticist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? .....  Yes  No
5. Has the patient had an ophthalmology examination and renal ultrasound at baseline (i.e., prior to starting therapy with the requested agent)? .....  Yes  No
6. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**For HPP requests:**

7. Is the patient experiencing active disease (e.g., bone pain, fractures, gait problems)? .....  Yes  No

**Please continue to the next page.**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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**For HPP requests:**

- **Please submit chart notes to support the answers to the following questions:**

8. Was the patient less than 18 years of age at onset? .....  Yes  No
9. Does/did the patient have clinical manifestations consistent with hypophosphatasia at the age of onset prior to age 18 (e.g., vitamin B6-dependent seizures, fractures, lost teeth with roots, skeletal abnormalities: such as rachitic chest deformity leading to respiratory problems or bowed arms/legs, "failure to thrive")? .....  Yes  No
10. Has molecular genetic testing been completed confirming mutations in the *ALPL* gene that encodes the tissue nonspecific isoenzyme of ALP (TNSALP)? .....  Yes  No
11. Does/did the patient have radiographic imaging confirming the diagnosis of hypophosphatasia at the age of onset prior to age 18 (e.g., infantile rickets, alveolar bone loss, craniosynostosis)? .....  Yes  No
12. Does the patient have reduced activity of unfractionated serum alkaline phosphatase (ALP) in the absence of bisphosphonate therapy (i.e., below the normal lab reference range for age and sex)? .....  Yes  No
13. Is there ONE of the following: 1) elevated serum concentration of pyridoxal 5'-phosphate (PLP) in the absence of vitamin supplements within one week prior to the test, 2) elevated urine concentration of phosphoethanolamine (PEA), or 3) elevated urinary inorganic pyrophosphate (PPi)? .....  Yes  No

**For renewal requests:**

14. Has the patient had clinical improvement from baseline (before treatment with the requested agent) in at least ONE of the following: 1) Respiratory status (e.g., level of respiratory support is required), 2) Growth (e.g., an improvement in length/height, weight, or head circumference as measured by z-scores), 3) Radiographic findings (e.g., improvement in skeletal manifestations as measured by RSS or RGI-C or a decrease in fractures), OR 4) Level of activity (e.g., improvement in motor function or activities in daily living)? **Please note, chart notes are required.** .....  Yes  No
15. Has the patient been monitored for signs and symptoms of ophthalmic and renal calcifications and for changes in vision or renal function? .....  Yes  No

**Please fax or mail this form to:**  
 Prime Therapeutics LLC  
 Clinical Review Department  
 2900 Ames Crossing Road Suite 200  
 Eagan, MN 55121

**TOLL FREE**

**Phone:** **Fax: 877.243.6930**  
**BCBSIL: 800.285.9426**  
**BCBSMT: 888.723.7443**  
**BCBSNM: 800.544.1378**  
**BCBSOK: 800.991.5643**  
**BCBSTX: 800.289.1525**

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