

# SUCRAID

## 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:	
<input type="checkbox"/> Congenital sucrase-isomaltase deficiency (CSID) <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

**For all requests:**

1. What is the patient's weight (in 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 FDA labeled contraindication: \_\_\_\_\_
4. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, geneticist, endocrinologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? .....  Yes  No
5. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**For congenital sucrase-isomaltase deficiency (CSID) requests**

6. Has the patient's diagnosis been confirmed by endoscopic biopsy of the small bowel indicating ALL of the following:
  - a) normal small bowel morphology
  - b) absent or markedly reduced sucrase activity
  - c) isomaltase activity varying from zero to full activity
  - d) reduced maltase activity? .....  Yes  No
7. If no, has the patient's diagnosis been confirmed by genetic testing of the sucrase-isomaltase (SI) gene indicating a pathogenic mutation? .....  Yes  No

**Please continue to the next page.**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
<b>For renewal requests:</b> 8. Has the patient had clinical benefit with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Please fax or mail this form to:</b> Prime Therapeutics LLC Clinical Review Department 2900 Ames Crossing Road Suite 200 Eagan, MN 55121 <b>TOLL FREE</b>		<b>CONFIDENTIALITY NOTICE:</b> This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.	
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