TRICARE Prior Authorization Request Form for
sacrosidase oral solution (Sucraid)

JOHNS HOPKINS
HEALTH PLANS
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USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Initial therapy approves for 12 months, and annual renewal is required. For renewal of therapy an initial Tricare prior authorization approval is required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: ____________________ Physician Name: ____________________
Address: ____________________ Address: ____________________
____________________ ____________________
Sponsor ID # ____________________ Phone #: ____________________
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

Question	Yes	No
1. **Has the patient received this medication under the TRICARE benefit in the last 6 months?** *Please choose "No" if the patient did not previously have a TRICARE approved PA for Sucraid.*	☐ Yes Proceed to question **6**	☐ No Proceed to question **2**
2. **Is the requested medication prescribed by a gastroenterologist?**	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. **Does the patient have a diagnosis of congenital sucrase-isomaltase deficiency (CSID) as diagnosed by endoscopic biopsy or genetic testing?**	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. **Has documentation been submitted to confirm that the patient has congenital sucrase-isomaltase deficiency (CSID)? NOTE: Medical documentation specific to your response to this question [for example, the progress note documenting that CSID was diagnosed via biopsy, and that Sucraid was recommended] must be attached to this case or your request could be denied.**	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**

5. Did the patient have symptomatic CSID (for example, diarrhea, bloating, abdominal cramping) prior to starting therapy with Sucraid despite appropriate dietary modification?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
6. Will the patient continue to follow dietary modification?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Have the patient's symptoms improved with Sucraid therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

_______________________________ Prescriber Signature

___________ Date

[02 October 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: