US Family Health Plan
Prior Authorization Request Form for
Sacrosidase Oral Solution (Sucraid)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

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:**

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]