Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Sucraid
(sacrosidase)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested: (*please specify name, strength, and dosing schedule)*

☐ Sucraid ICD10:

Dose: Frequency of therapy: Duration of therapy:

Current weight: _____ kg/lb
Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples of Sucraid, please choose "new start of therapy". ☐ new start of therapy ☐ continued established therapy ☐ Start date: _____
(if continued therapy) Is your patient having a beneficial clinical response to therapy with this drug? Supportive documentation is required. ☐ Yes ☐ No

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Clinical Information:
****This drug requires supportive documentation (genetic test results, chart notes, lab/test results, etc) be attached with this request****

Does your patient have a diagnosis of congenital sucrase-isomaltase deficiency (CSID, genetic sucrase-isomaltase deficiency, GSID)?
Yes ☐ No ☐ (please specify): _____
Prior to Sucraid, was/is your patient experiencing symptoms of CSID (for example, diarrhea, bloating, abdominal cramping)?
Yes ☐ No ☐

Does your patient have ONE of the following? Please provide genetic testing results.
☐ documented homozygous and pathogenic mutation in the sucrase-isomaltase (SI) gene
☐ documented homozygous and likely pathogenic mutation in the sucrase-isomaltase (SI) gene
☐ documented compound heterozygous and pathogenic mutation in the sucrase-isomaltase (SI) gene
☐ documented compound heterozygous and likely pathogenic mutation in the sucrase-isomaltase (SI) gene
☐ none of the above

(if none of the above) Did your patient have an endoscopic biopsy of the small bowel? Yes ☐ No ☐

(if yes) Did the biopsy show a decreased (or absent) sucrase as evidenced by either of the following?
☐ 25 U/g or less protein
☐ protein result was below the reporting lab's normal reference range
☐ neither of the above

(if yes) Did the biopsy show a decreased to normal isomaltase (palatinase) as evidenced by either of the following?
☐ 5 U/g or less protein
☐ protein result was below the reporting lab's normal reference range
☐ neither of the above

(if yes) Did the biopsy show a decreased maltase as evidenced by either of the following?
☐ 100 U/g or less protein
☐ protein result was below the reporting lab's normal reference range
☐ neither of the above

(if yes) Did the biopsy show a decreased to normal lactase as evidenced by either of the following?
☐ 15 U/g or less protein
☐ protein result was below the reporting lab's normal reference range
☐ neither of the above

Additional pertinent information: (*please include clinical reasons for drug, relevant lab values, etc.)*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

v020119