PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Strensiq® (asfotase alfa injection)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product:

☐ Strensiq 18 mg/0.45 mL vial
☐ Strensiq 28 mg/0.7 mL vial
☐ Strensiq 40 mg/1 mL vial
☐ Strensiq 80 mg/0.8 mL vial

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dose: _____

Dosing frequency: _____

Patient's weight (kg): _____

Drug cost information

The cost of treatment with this drug may be more than $800,000 each year.

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Must have perinatal/infantile or juvenile-onset hypophosphatasia.
2. Clinical manifestations consistent with hypophosphatasia must be present.
3. Diagnosis must be confirmed with both biochemical and molecular genetic testing.
4. A second opinion may be required by Priority Health from a Specialist Provider we choose to help us determine whether Strensiq is medically necessary.

The FDA-approved labeling allows for Strensiq to be injected three times per week or six times per week. Strensiq is only covered as a three times per week injection.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2016

Last reviewed 01/2019

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ perinatal/infantile hypophosphatasia
- ☐ juvenile-onset hypophosphatasia
- ☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. Please indicate which of the following clinical manifestations are present

a. Skeletal
- ☐ Rickets
- ☐ Osteomalacia
- ☐ Nonhealing factures
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Craniosynostosis

b. Dental
- ☐ Premature tooth loss
- ☐ Periodontal disease

C. Please provide the following:

a. Alkaline phosphatase (ALP) activity: _____
b. Serum pyridoxal phosphate (PLP):_____
c. Urinary phosphoethanolamine (PEA):_____

D. Has an ALPL gene mutation been confirmed with molecular genetic testing?

- ☐ Yes
- ☐ No

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