

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 **Start date** (or date of next dose): _____
 Strensiq 28 mg/0.7 mL vial **Date of last dose** (if applicable): _____
 Strensiq 40 mg/1 mL vial **Dose:** _____
 Strensiq 80 mg/0.8 mL vial **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.

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 fractures
- 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