maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Strensiq

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	What is the diagnosis or indication? [] Perinatal/infantile-onset hypophosphatasia (If checked, go to 2) [] Juvenile-onset hypophosphatasia (If checked, go to 2) [] Other (If checked, no further questions)		
2	Did the patient have a disease onset at 18 years of age or younger? [If no, no further questions.]	Yes	No
3	Has the requested medication been prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who	Yes	No

If you have any questions, call:
1-888-258-8250

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	specializes in the treatment of hypophosphatasia or related disorders? [If no, no further questions.]		
4	Has the patient undergone molecular genetic testing which documents a tissue non-specific alkaline phosphatase (ALPL) gene mutation? [If yes, skip to question 7.]	Yes	No
5	Does the patient have low baseline serum alkaline phosphatase activity? [If yes, skip to question 7.]	Yes	No
6	Does the patient have an elevated level of a tissue non-specific alkaline phosphatase substrate (i.e., serum pyridoxal 5'-phosphate, serum or urinary inorganic pyrophosphate, urinary phosphoethanolamine)? [If no, no further questions.]	Yes	No
7	Does the patient have a history of or currently have clinical manifestations consistent with hypophosphatasia (for example, skeletal abnormalities, premature tooth loss, muscle weakness, poor feeding, failure to thrive, respiratory problems, Vitamin B6-dependant seizures)? [If yes, no further questions.]	Yes	No
8	Does the patient have a family history (parent ot sibling) of hypophosphatasia without current clinical manifestations of hypophosphatasia?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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