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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is this request for initial therapy or for a continuation of therapy?

[] Initial (If checked, go to 7)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 7.]

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

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3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	What is the diagnosis or indication? [] Perinatal/infantile onset hypophosphatasia (If checked, go to 8) [] Juvenile-onset hypophosphatasia (If checked, go to 8) [] Other (If checked, no further questions)		
8	Did the patient have a disease onset at 18 years of age or younger? [If no, no further questions.]	Yes	No
9	Has the requested medication been prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of hypophosphatasia or related disorders? [If no, no further questions.]	Yes	No
10	Has the patient undergone molecular genetic testing which documents a tissue non-specific alkaline phosphatase (ALPL) gene mutation? [If yes, skip to question 13.]	Yes	No
11	Does the patient have low baseline serum alkaline phosphatase activity? [If yes, skip to question 13.]	Yes	No
12	Does the patient have an elevated level of a tissue non-specific alkaline phosphatase substrate (for example, serum pyridoxal 5'-phosphate, serum or urinary inorganic pyrophosphate, and urinary phosphoethanolamine)? [If no, no further questions.]	Yes	No
13	Does the patient have a history of or currently have clinical manifestations consistent with hypophosphatasia (for example, skeletal abnormalities, premature tooth loss, muscle	Yes	No

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	weakness, poor feeding, failure to thrive, respiratory problems, or vitamin B6-dependent seizures)? [If yes, no further questions.]		
14	Does the patient have a family history (parent or 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.

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