AETNA BETTER HEALTH®
Non-Formulary Prior Authorization guideline for Sucraid

Authorization guidelines
May be authorized when the following criteria are met:

- Prescribed by a gastroenterologist, endocrinologist, or genetic specialist
- Member does not have secondary (acquired) disaccharidase deficiencies
- Documentation to support the diagnosis of congenital sucrose-isomaltase deficiency has been submitted:
  - Diagnosis of congenital sucrose-isomaltase deficiency has been confirmed by low sucrose activity on duodenal biopsy and other disaccharidases normal on same duodenal biopsy
  - If small bowel biopsy is clinically inappropriate, difficult, or inconvenient to perform, the following diagnostic tests are acceptable alternatives (all must be performed and results submitted):
    - Stool pH less than 6; AND
    - Breath hydrogen increase greater than 10 ppm following fasting sucrose challenge; AND
    - Negative lactose breath test

Additional Information:
Sucraid is NOT covered for members with the following criteria:

- Use not approved by the FDA; AND
- The use is unapproved and not supported by the literature or evidence as an accepted off-label use.

Approval Duration:
Initial Approval: 1 month
Renewal: 12 months
Requires: Documentation to support a response to treatment with Sucraid.

Medically Necessary — A service or benefit is Medically Necessary if it is compensable under the MA Program and if it meets any one of the following standards:
• The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.

• The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

• The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or exception basis, must be documented in writing.

The determination is based on medical information provided by the Member, the Member’s family/caretaker and the Primary Care Practitioner, as well as any other Providers, programs, agencies that have evaluated the Member.

All such determinations must be made by qualified and trained Health Care Providers. A Health Care Provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this Agreement.

References: