

PRIOR AUTHORIZATION CRITERIA

BRAND NAME
(generic)

SUCRAID
(sacrosidase)

Status: CVS Caremark® Criteria

Type: Initial Prior Authorization with Quantity Limit

POLICY

FDA-APPROVED INDICATIONS

Sucraid (sacrosidase) Oral Solution is indicated as oral replacement therapy of the genetically determined sucrose deficiency, which is part of congenital sucrose-isomaltase deficiency (CSID).

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- The patient has a diagnosis of congenital sucrose-isomaltase deficiency
 - AND**
 - The diagnosis of congenital sucrose-isomaltase deficiency was confirmed by small bowel biopsy
 - OR**
 - The diagnosis of congenital sucrose-isomaltase deficiency was confirmed by genetic testing
 - OR**
 - The diagnosis of congenital sucrose-isomaltase deficiency was confirmed by sucrose hydrogen breath test

Quantity Limits apply.

QUANTITY LIMIT

PLEASE NOTE: Since manufacturer package sizes may vary, it is the discretion of the dispensing pharmacy to fill quantities per package size up to these quantity limits. In such cases the filling limit and day supply may be less than what is indicated.

Drug	1 Month Limit*	3 Month Limit*
Sucraid Multiple-Dose Bottle (Each bottle contains 4 oz [118 mL total])	354 mL / 25 days	1062 mL / 75 days
Sucraid Single-Use Container (Each carton contains 150 single-use containers of 2 mL each [300 mL total])	300 mL/ 21 days	900 mL/ 63 days

**The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing OR the duration of 21 days is used for a 25-day fill period and 63 days is used for a 75-day fill period to allow time for refill processing.*

Duration of Approval (DOA):

- 3369-C: DOA: 12 months

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REFERENCES

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