UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2023 P 1176-9
Program	Prior Authorization/Notification
Medication	Strensiq™ (asfotase alfa)
P&T Approval Date	2/2016, 12/2016, 11/2017, 11/2018, 11/2019, 11/2020, 11/2021, 11/2022, 11/2023
Effective Date	2/1/2024

1. Background:

Strensiq (asfotase alfa) is a tissue nonspecific alkaline phosphatase indicated for the treatment of patients with perinatal/infantile and juvenile-onset hypophosphatasia (HPP).

2. Coverage Criteria[a]:

A. Initial Authorization

1. **Strensiq** will be approved based on **one** of the following criteria:

   a. Diagnosis of perinatal/infantile-onset hypophosphatasia

   -OR-

   b. Diagnosis of juvenile-onset hypophosphatasia

   Authorization will be issued for 12 months.

B. Reauthorization

1. **Strensiq** will be approved based on the following criterion:

   a. Documentation of positive clinical response to Strensiq therapy

   Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Strensiq [package insert]. Boston, MA: Alexion Pharmaceuticals, Inc.; June 2020.

Program	Prior Authorization/Notification - Strensiq (asfotase alfa)
Change Control	
2/2016	New program.
12/2016	Annual Review. Revised background. Extended initial authorization to 12 months.
11/2017	Annual Review. Updated references.
11/2018	Annual Review. Updated references.
11/2019	Annual Review. No changes.
11/2020	Annual review. Updated reference.
11/2021	Annual review with no changes to clinical coverage criteria.
11/2022	Annual review with no changes to clinical coverage criteria. Added state mandate footnote.
11/2023	Annual review with no changes to clinical coverage criteria.