UnitedHealthcare Community Plan

Strensiq
PRIOR AUTHORIZATION REQUEST FORM

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication ☐ New or ☐ Continuation of Therapy? If continuation, list start date: ________________
Is this patient currently hospitalized? ☐ Yes ☐ No If recently discharged, list discharge date: ________________

Section B - Physician Information

First Name:		Last Name: M.D./D.O.		
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? ☐ Yes ☐ No If yes, what is this member's due date? _______________

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs
Please refer to www.uhccommunityplan.com for a list of preferred alternatives

☐ ***The information provided is true and accurate to the best of their knowledge and they understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided.***

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

- Does the patient have a diagnosis of perinatal/infantile or juvenile-onset hypophosphatasia? □ Yes □ No
If no, list diagnosis: ____

- Patient's weight: ____________

- Is the patient's diagnosis based on one of the following: □ Yes □ No (check which apply)
- □ Onset of clinical signs and symptoms of hypophosphatasia prior to age 18 (e.g. respiratory insufficiency, vitamin B6 responsive seizures, hypotonia, failure to thrive, delayed walking, waddling gait, dental abnormalities, low trauma fractures)
- □ Radiographic evidence supporting the diagnosis of hypophosphatasia at the age of onset prior to age 18 (e.g. craniosynostosis, infantile rickets, non-traumatic fractures)

- Does the patient have confirmed tissue-nonspecific alkaline phosphatase (TNSALP) gene mutation by ALPL genomic DNA testing? □ Yes □ No

- Does the patient have low level activity of serum alkaline phosphatase (ALP) evidenced by an ALP level below the age and gender-adjusted normal range? □ Yes □ No

- Does the patient have an elevated level of tissue non-specific alkaline phosphatase (TNSALP) substrate (e.g. serum pyridoxal 5'-phosphate [PLP] level, serum or urine phosphoethanolamine [PEA] level, urinary inorganic pyrophosphate [PPi level])? □ Yes □ No

- Is the requested dosage within the plan's maximum supply limit of one of the following: □ Yes □ No (check which apply)
- □ For patients with a diagnosis of perinatal/infantile hypophosphatasia: maximum supply limit of 9mg/kg/week
- □ For patients with a diagnosis of juvenile-onset hypophosphatasia: maximum supply limit of 6mg/kg/week

- Is Strensiq prescribed by one of the following: □ Yes □ No (check which applies)
□ Endocrinologist □ A specialist experienced in the treatment of metabolic bone disorders

Requests for Continuation of Therapy:

- Does the patient have a clinically relevant decrease from baseline in tissue non-specific alkaline phosphatase (TNSALP) substrate (e.g. serum pyridoxal 5'-phosphate [PLP] level, serum or urine phosphoethanolamine [PEA] level, urinary inorganic pyrophosphate [PPi level])? □ Yes □ No

Physician Signature: ____ Date: ________________

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Website: uhccommunityplan.com