PRIOR AUTHORIZATION CRITERIA

BRAND NAME
(generic)

SUCRAID
(sacrosidase)

Status: CVS Caremark Criteria
Type: Initial Prior Authorization with Quantity Limit

POLICY

FDA-APPROVED INDICATIONS
Sucraid is indicated as oral replacement therapy of the genetically determined sucrase deficiency, which is part of congenital sucrase-isomaltase deficiency.

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

- The patient has a diagnosis of congenital sucrase-isomaltase deficiency

AND

- The diagnosis of congenital sucrase-isomaltase deficiency was confirmed by small bowel biopsy
  OR
- The diagnosis of congenital sucrase-isomaltase deficiency was confirmed by genetic testing
  OR
- The diagnosis of congenital sucrase-isomaltase deficiency was confirmed by sucrose hydrogen breath test

Quantity Limits apply.
3 bottles (354 mL) per month

REFERENCES

1. Sucraid [package insert]. Vero Beach, FL: QOL Medical, LLC; September 2018.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Hudson, OH: Wolters Kluwer Clinical Drug Information, Inc. http://online.lexi.com/. Accessed August 2020.
3. Micromedex (electronic version). Truven Health Analytics, Greenwood Village, Colorado, USA. http://www.micromedexsolutions.com/. Accessed August 2020.
4. National Organization for Rare Disorders (NORD). Congenital Sucrase-Isomaltase Deficiency. 2005. Available at https://rarediseases.org. Accessed August 2020.
5. Genetic and Rare Diseases Information Center. Congenital sucrose-isomaltase deficiency. 2020. Available at https://rarediseases.info.nih.gov. Accessed August 2020.