## CAREFIRST F1

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

**Patient Information**

**Patient Name:**

**Patient Phone:** - -

**Patient ID:**

**Patient Group No:**

**Patient DOB:** / /

**Prescribing Physician**

Physician Name:

**Physician Phone:** - -

**Physician Fax:** - -

**Physician Address:**

**City, State, Zip:**

**Drug Name (select from list of drugs shown)**

Sucraid 8500 I.U./mL Oral Solution
(sacrosidase)

**Quantity:** _____ **Frequency:** _____ **Strength:** _____

**Route of Administration:** _____ **Expected Length of Therapy:** _____

**Diagnosis:** _____ **ICD Code:** _____

**Comments:** _____

**Please check the appropriate answer for each applicable question.**

1. Does the patient have a diagnosis of congenital sucrase-isomaltase deficiency? **Y** ☐ **N** ☐
2. Was the diagnosis of congenital sucrase-isomaltase deficiency confirmed by small bowel biopsy? **Y** ☐ **N** ☐
3. Was the diagnosis of congenital sucrase-isomaltase deficiency confirmed by genetic testing? **Y** ☐ **N** ☐
4. Does the patient require an amount for coadministration with more than three meals and three snacks per day with the requested drug? **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

**Prescriber (Or Authorized) Signature and Date**

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