Strensiq® (asfotase alfa) Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Metabolic Specialist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Strensiq (asfotase alfa)**: Dose:** _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required):

☐ Yes ☐ No Does the patient have a documented diagnosis of hypophosphatasia (HPP)?
Please indicate the onset of the diagnosis: ☐ Perinatal ☐ Juvenile ☐ Adult ☐ Other please explain: _____
Please indicate the patient's weight (in kilograms): _____
Please indicate the weekly dose (in milligrams) being prescribed: _____

For Initiation Requests (clinical documentation required):

☐ Yes ☐ No Does the patient have documentation of the presence of hypophosphatasia before the age of 18 (e.g., member began experiencing symptoms at age 10)?

☐ Yes ☐ No Does the patient have clinical signs and symptoms of hypophosphatasia (e.g., skeletal abnormalities, respiratory problems, hypercalcemia, seizures)?

☐ Yes ☐ No Did the patient test positive for a known pathological mutation in the ALPL gene as determined by molecular genetic testing?

→ ☐ Yes ☐ No Do findings on radiographic imaging at the time of diagnosis demonstrate skeletal abnormalities and support the diagnosis of hypophosphatasia (e.g., infantile rickets, alveolar bone loss, osteoporosis, low bone mineral content for age [as detected by DEXA])?

→ Please provide the ALP level and date obtained: _____ IU/L Date: ____/____/____
How does the patient's pretreatment serum alkaline phosphatase (ALP) level compare to the laboratory's reference normal range based on age and gender? ☐ Higher than the laboratory's normal range
☐ Lower than the laboratory's normal range
☐ Within the laboratory's normal range

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ Yes ☐ No Does the patient have an elevated pretreatment substrate level of a tissue-nonspecific alkaline phosphatase (TNSALP) (e.g., serum pyridoxal 5'-phosphate [PLP] level, urine phosphoethanolamine [PEA] level, urinary or plasma inorganic pyrophosphate [PPi level]) as defined by the laboratory performing the test?

☐ Yes ☐ No Were ALL of the following documentation submitted with this request?

- ☐ Radiographic imaging demonstrating skeletal abnormalities
- ☐ A serum alkaline phosphatase level below the gender and age-specific reference range of the laboratory performing the test
- ☐ Elevated TNSALP substrate level (e.g., serum PLP level, urine PEA level, urinary or plasma PPi level)

For Continuation Requests (clinical documentation required):

☐ Yes ☐ No Is the patient currently receiving the requested medication through samples or a manufacturer's patient assistance program?

☐ Yes ☐ No Is the patient experiencing benefit from therapy as demonstrated by an improvement in skeletal manifestations from baseline as assessed by the Radiographic Global Impressions of Change (RGI-C) scale?

→ ☐ Yes ☐ No Is the patient less than 18 years of age and is experiencing benefit from therapy as demonstrated by an improvement in height and weight compared to baseline, as measured by z-scores?

→ ☐ Yes ☐ No Is the patient experiencing benefit from therapy as demonstrated by an improvement in step length by at least 1 point in either foot compared to baseline based on the Modified Performance Oriented Mobility Assessment-Gait (MPOMA-G) scale?

→ ☐ Yes ☐ No Is the patient experiencing benefit from therapy as demonstrated by an improvement in the 6 Minute Walk Test compared to baseline?

→ ☐ Yes ☐ No Is the patient experiencing benefit from therapy as demonstrated by an improvement in the Timed Up & Go (TUG) Test compared to baseline?

→ ☐ Yes ☐ No Is the patient experiencing benefit from therapy as demonstrated by an improvement in the Chair Rise Test compared to baseline?

→ ☐ Yes ☐ No Is the patient experiencing benefit from therapy demonstrated by an improvement in the Lower Extremity Function scale (LEFS) compared to baseline?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.