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:
Phone: 1-866-503-0857
FAX: 1-844-268-7263

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: 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: _____

For Initiation Requests:

☐ Yes ☐ No Did the patient demonstrate clinical signs and symptoms of hypophosphatasia (e.g., skeletal abnormalities, respiratory problems, hypercalcemia, seizures) before the age of 18?
→ **ACTION REQUIRED**: If yes, submit medical record documentation showing presence of condition before the age of 18

☐ Yes ☐ No Does the patient currently demonstrate 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?
ACTION REQUIRED: If yes, submit genetic test results
Please provide the ALP level and date obtained: _____ IU/L Date: ____/____/____

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

Continued on next page

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:
Phone: 1-866-503-0857
FAX: 1-844-268-7263

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** level of a tissue-nonspecific alkaline phosphatase (TNSALP) substrate (i.e., serum pyridoxal 5'-phosphate [PLP] level, serum or urine phosphoethanolamine [PEA] level, urinary inorganic pyrophosphate [PPi level])?

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

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

For Continuation Requests:

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

☐ Yes ☐ No Did the patient experience benefit from therapy (e.g., improvement in skeletal manifestations, growth, gait/mobility, muscle strength) since starting the requested medication?

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.