Effective Date: 4/2020
Reviewed: 1/2020
Scope: Medicaid

SPECIALTY GUIDELINE MANAGEMENT

Sucraid (Sacrosidase)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication
Treatment of congenital sucrose-isomaltase deficiency.
All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Congenital sucrose-isomaltase deficiency (CSID)

Authorization of 3 months may be granted for treatment of CSID for members who are at least 5 months of age or older when all of the following criteria are met:

1. Sucraid is prescribed by a gastroenterologist, endocrinologist, or genetic specialist AND
2. Member's current weight is provided (for the purpose of dose calculations) AND
3. Patient has a diagnosis of congenital sucrose-isomaltase deficiency confirmed by EITHER (A) OR (B):
   a. Duodenal biopsy showing low sucrose activity (less than 25 units) and normal amounts of other disaccharides OR
   b. Meeting all of the following criteria:
      - Stool pH <6
      - Increase in breath hydrogen of >10ppm when challenged with sucrose after fasting
      - Negative lactose breath test

III. CONTINUATION OF THERAPY

Authorization of 6 months may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response with Sucraid as defined as at least 50% reduction in symptoms (e.g: abdominal pain, cramps, bloating, gas, vomiting, diarrhea, number of stools per day, and number of symptomatic days)

IV. QUANTITY LIMIT

Coverage is available for a quantity sufficient to allow for FDA-approved dosing:
> 15kg: 2mL with each meal or snack
≤15kg: 1mL with each meal or snack