UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 1268-6
Program	Prior Authorization/Notification
Medication	Sucraid (sacrosidase) oral solution
P&T Approval Date	12/2018, 12/2019, 1/2021, 1/2022, 1/2023, 1/2024
Effective Date	4/1/2024

1. Background:
Sucraid (sacrosidase) is an oral enzyme replacement therapy indicated for the treatment of genetically determined sucrase deficiency, which is part of congenital sucrase-isomaltase deficiency (CSID).

2. Coverage Criterion[a]:

A. Initial Authorization

1. **Sucraid** will be approved based on the following criterion:

   a. Diagnosis of congenital sucrase-isomaltase deficiency.

   Authorization will be issued for 12 months.

B. Reauthorization

1. **Sucraid** will be approved based on the following criterion:

   a. Documentation of positive clinical response to Sucraid therapy.

   Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:
- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class

4. References:
1. Sucraid [package insert]. Vero Beach, FL: QOL Medical, LLC; May 2023.

Program	Prior Authorization/Notification – Sucraid
Change Control	
12/2018	New program
12/2019	Annual review, no changes.
1/2021	Annual review. Updated references.
1/2022	Annual review with no changes to coverage criteria. Updated reference.
1/2023	Annual review with no changes to coverage criteria. Added state mandate footnote and updated reference.
1/2024	Annual review with no changes to coverage criteria. Updated reference.