



**GEORGIA MEDICAID FEE-FOR-SERVICE  
STRENSIQ PA SUMMARY**

Preferred	Non-Preferred
Strensiq (asfotase alfa)	n/a

**LENGTH OF AUTHORIZATION:** Initial 6 months; repeat 1 year

**PA CRITERIA:**

- ❖ Approvable for members with perinatal/infantile-onset or juvenile-onset hypophosphatasia (HPP) with low baseline serum alkaline phosphatase (ALP) activity ( $\leq 160$  U/L)

*AND*

- ❖ Diagnosis must be confirmed by either genetic testing, an elevated urine concentration of phosphoethanolamine (PEA) or an elevated serum concentration of pyridoxal 5'-phosphate (PLP)

*AND*

- ❖ Member must be monitored for ectopic calcifications of the eyes and kidneys with ophthalmologic examinations and renal ultrasounds at baseline and periodically during treatment.

**EXCEPTIONS:**

- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.
- ❖ The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827**.

**PREFERRED DRUG LIST:**

- ❖ For online access to the Preferred Drug List (PDL), please go to <http://dch.georgia.gov/preferred-drug-lists>.

**PA AND APPEAL PROCESS:**

- ❖ For online access to the PA process, please go to [www.dch.georgia.gov/prior-authorization-process-and-criteria](http://www.dch.georgia.gov/prior-authorization-process-and-criteria) and click on Prior Authorization (PA) Request Process Guide.

**QUANTITY LEVEL LIMITATIONS:**

- ❖ For online access to the current Quantity Level Limits (QLL), please go to [www.mmis.georgia.gov/portal](http://www.mmis.georgia.gov/portal), highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.