# ALASKA MEDICAID Prior Authorization Criteria

# Strensiq<sup>TM</sup> (asfotase alfa)

#### FDA INDICATIONS AND USAGE<sup>1</sup>

Strensiq<sup>TM</sup> is a tissue nonspecific alkaline phosphatase indicated for the treatment of patients with perinatal/infantile- and juvenile- onset hypophosphatasia (HPP).

#### APPROVAL CRITERIA<sup>1,2,3</sup>

- 1. Medication is being prescribed by or in consultation with an endocrinologist or a specialist experienced in treating metabolic disorders **AND**;
- 2. Patient has a documented diagnosis of perinatal/infantile- or juvenile- onset hypophosphatasia confirmed by elevated urine concentration of phosphoethanolamine (PEA), elevated serum concentration of pyridoxal 5'-phosphate (PLP) in the absence of vitamin supplements within one week prior, or elevated urinary inorganic pyrophosphate (PPi) **AND**;
- 3. The patient was less than 18 years of age at onset **AND**;
- 4. The patient has clinical manifestations of hypophosphatasia (I.E. skeletal abnormalities, respiratory problems, failure to thrive, rickets, etc.) **AND**;
- 5. The patient has had a low baseline ALP activity adjusted for age **AND**;
- 6. Patient has at least one variant in the ALPL gene.

#### **DENIAL CRITERIA**<sup>1,2</sup>

- 1. Failure to meet approval criteria **OR**;
- 2. The provider has failed to provide the patients weight for dosing.
- 3. The formulation is inappropriate for the patient's weight.
  - The 80mg/0.8ml formulation is limited to patients ≥40kg due to significant differences in bioavailability relative to the other concentrations.

#### **CAUTIONS**<sup>1</sup>

- Hypersensitivity reactions have occurred including anaphylaxis.
- Lipodystrophy has been observed and is recommended to rotate injection sites.
- Monitor for Ectopic Calcifications in the eye and kidney using ophthalmologic examinations and renal ultrasounds at baseline and periodically during treatment.

#### **DURATION OF APPROVAL**

• Approval: Up to 3 months

• Reauthorization: Up to 12 months

Strensiq® Criteria Version: 2 Original: 07/15/20 Updated: 11/17/2023 Effective: 01/01/2024

## ALASKA MEDICAID Prior Authorization Criteria

## **OUANTITY LIMITS**

• Up to a maximum of 9mg/kg per week

#### **REFERENCES / FOOTNOTES:**

- 1. Strensiq<sup>TM</sup> [Package Insert]. Boston, MA. Alexion Pharmaceutical, INC; June 2020. Available at: https://alexion.com/documents/strensiq\_uspi Accessed: July 15, 2020.
- 2. Hypophosphatasia. U.S.National Library of Medicine. September 2017. Published January 2018. Accessed: July 15, 2020.
- 3. Whyte MP, Mahuren JD, Vrabel LA, Coburn SP. Markedly increased circulating pyridoxal-5'-phosphate levels in hypophosphatasia. J Clin Invest. 1985;76(2):752-756.

Strensiq® Criteria Version: 2 Original: 07/15/20 Updated: 11/17/2023 Effective: 01/01/2024