PRIOR AUTHORIZATION REQUEST
Cystagon

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. What is the indication or diagnosis?
   - ☐ Cystinosis, nephropathic
   - ☐ Other indications - Please specify _____
2. ☐ Yes ☐ No Is the requested medication prescribed by or in consultation with a nephrologist or a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)?
3. ☐ Yes ☐ No According to the prescriber has genetic testing confirmed a mutation of the CTNS gene?
4. ☐ Yes ☐ No According to the prescriber, does the patient have white blood cell cystine concentration above the upper limit of the normal reference range for the reporting laboratory?
5. ☐ Yes ☐ No Will the patient be taking Cystagon and Procysbi in combination?

Please document the diagnoses, symptoms, and/or any other information important to this review:

_____

_____

SECTION B Physician Signature

_____
PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a

If you have any questions, call: 800-753-2851

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covered Health Plan Benefit and medically necessary with prior

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