Prescriber Criteria Form

Cysteamine Ophth 2025 PA Fax 926-A v1 010125.docx
Cystaran, Cystadrops (cysteamine ophthalmic solution)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Cysteamine Ophth.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of cystinosis? [If no, then no further questions.]	Yes	No
2	Was the diagnosis confirmed by ANY of the following: A) the presence of increased cystine concentration in leukocytes, B) genetic testing, C) demonstration of corneal cystine crystals by slit lamp examination? [If no, then no further questions.]	Yes	No
3	Does the patient have corneal cystine crystal accumulation?	Yes	No

Comments: ____________________

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: ________________________________ Date:____________________