

**PRIOR AUTHORIZATION REQUEST FORM
CYSTADROPS® AND CYSTARAN® FOR OCULAR CYSTINOSIS**

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: Cystadrops® 0.37% (cysteamine ophthalmic gel solution), Cystaran® 0.44% (cysteamine ophthalmic solution)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the prescribing provider a corneal specialist?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation show a diagnosis of cystinosis including a leukocyte cysteine concentration of > 1.5 nmol half-cysteine per milligram of protein?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Does the member have cystine corneal crystals as shown by slit lamp examination?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Does documentation include a baseline Corneal Cystine Crystal Score (CCCS)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation show a reduction of ≥ 1 unit in the Corneal Cystine Crystal Score (CCCS) after 6 months treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Does documentation show an improvement in vision?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

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Additional information:

Physician Signature:

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Policy: PHARM- 104
Origination Date: 10/07/2020
Reviewed/Revised Date: 10/28/2020
Next Review Date: 10/28/2021
Current Effective Date: 11/01/2020

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