

Prescriber Criteria Form

Cystagon 2026 PA Fax 803-A v1 010126.docx
 Cystagon (cysteamine bitartrate)
 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 Cystagon (cysteamine bitartrate).

Drug Name:
 Cystagon (cysteamine bitartrate)

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 nephropathic 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?	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:** _____