

Prescriber Criteria Form

Cysteamine Opth 2026 PA Fax 926-A v1 010126.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 Opth.

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:** \_\_\_\_\_