HEALTHY U CHIP

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 Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

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?	☐	☐	
2. Does documentation show a diagnosis of cystinosis including a leukocyte cysteine concentration of > 1.5 nmol half-cysteine per milligram of protein?	☐	☐	**Please provide documentation**
3. Does the member have cystine corneal crystals as shown by slit lamp examination?	☐	☐	**Please provide documentation**
4. Does documentation include a baseline Corneal Cystine Crystal Score (CCCS)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show a reduction of ≥ 1 unit in the Corneal Cystine Crystal Score (CCCS) after 6 months treatment?	☐	☐	**Please provide documentation**
3. Does documentation show an improvement in vision?	☐	☐	**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.

Additional information:
Physician Signature:

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Policy: PHARM-CHIP-104
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024