Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

CVS caremark™ {{PANUMCODE}}

Cystaran, Cystadrops

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. Which drug is being prescribed? ❑ Cystaran ❑ Cystadrops
2. What is the diagnosis?
   ❑ Cystinosis
   ❑ Other _____
3. What is the ICD-10 code? _____
4. Is this a request for continuation of therapy with the requested medication for treatment of corneal cystine crystal accumulation with cystinosis? ❑ Yes ❑ No *If No, skip to #7*
5. Did the patient experience a **decrease** in corneal cystine crystal accumulation?
   If Yes, no further questions. ❑ Yes ❑ No
6. Did the patient experience an **increase** in corneal cystine crystal accumulation?
   ❑ Yes ❑ No *No further questions.*
7. Was the diagnosis confirmed by the presence of increased cystine concentration in leukocytes OR by genetic testing? ***ACTION REQUIRED: If Yes, attach test results detecting an increased cystine concentration in leukocytes or genetic testing results supporting diagnosis.*** ❑ Yes ❑ No
8. Does the patient have corneal cystine crystal accumulation? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

 Cystaran, Cystadrops SGM - 8/2021.