Procysbi

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: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the diagnosis?
   ❑ Nephropathic cystinosis ❑ Other _____
2. What is the ICD-10 code? _____
3. The preferred product for your patient's health plan is Cystagon. Can the patient's treatment be switched to the preferred product? ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   ❑ Yes - Cystagon ❑ No - Continue request for Procysbi
4. Has the patient experienced a documented intolerable adverse event with the preferred product?
   ACTION REQUIRED: If Yes, attach supporting chart note(s). ❑ Yes ❑ No
5. Is this a request for continuation of therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #7*
6. Is the patient responding to therapy (e.g., improvement, stabilization, or slowing of disease progression for serum creatinine, calculated creatinine clearance, leukocyte cystine concentration, or maintained growth [height])?
   ACTION REQUIRED: If Yes, supporting chart notes or lab results are required.
   ❑ 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. Will the patient be using the requested medication in combination with Cystagon? ❑ Yes ***q*** 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

 Procysbi VF, ACSF SGM - 1/2023.