Thiola, Thiola EC

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.

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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 drug is being prescribed? ❑ Thiola ❑ Thiola EC ❑ tiopronin
2. What is the diagnosis?
   ❑ Severe homozygous cystinuria (bialleclic mutations/variants in the SLC3A1 or the SLC7A9 gene)
   ❑ Other _____
3. What is the ICD-10 code? _____
4. The preferred product for your patient's health plan is tiopronin. Can the patient's treatment be switched to the preferred product? ***If Yes, fax a new prescription to the pharmacy and skip to #8.***
   ❑ Yes - tiopronin
   ❑ No - Continue request for non-preferred product
   ❑ Not applicable - Requested product is preferred, *skip to #8*
5. Has the patient failed treatment with tiopronin due to an intolerable adverse event (e.g., rash, nausea, vomiting)?
   ❑ Yes ❑ No
6. Was the intolerable adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the brand and generic medication)?
   ❑ Yes ❑ No
7. Was this adverse event documented in the patient's chart? *Documentation is required for approval. Provide **SPECIFIC and DETAILED** chart documentation including description, date/time, and severity of the adverse event, dosage and duration of generic medication treatment, required intervention (if any), and relevant tests or laboratory data (if any) **OR** MedWatch form of this trial and failure including the adverse reaction.*
   ❑ Yes ❑ No
8. Is the patient currently receiving the requested drug? ❑ Yes ❑ No *If No, skip to #10*
9. Has the patient experienced a decrease in urinary cystine levels compared to pretreatment baseline?
   ACTION REQUIRED: If Yes, attach supporting chart note(s) or lab results for urinary cystine levels.
   ❑ Yes ❑ No *No further questions*

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

10. Has the diagnosis of homozygous cystinuria (bialleclic mutations/variants in the SLC3A1 or the SLC7A9 gene) been confirmed by genetic testing showing mutation in both alleles of the SLC3A1 or SLC7A9 genes? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) or test results.*** ❑ Yes ❑ No

11. Is the requested drug being used as an adjunct to high fluid intake, alkali, and diet modification? ❑ Yes ❑ No

12. Does the patient have elevated urinary cystine levels at baseline? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) or lab results for urinary cystine levels.*** ❑ 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)**

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