PROCYSBI
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit *www.myprime.com*. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

☐ Standard review
☐ Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: ___________________

PATIENT AND INSURANCE INFORMATION **Date of Service (if differs from Today's Date): ___________________**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis – ICD code plus description:	
Agent Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. Is the patient currently treated with the requested agent? ☐ Yes ☐ No

   If yes, is the patient currently stable on the requested agent? **Please note, chart notes are required.** ☐ Yes ☐ No

2. Does the patient have any FDA labeled contraindications to the requested agent? ☐ Yes ☐ No

   If yes, please specify contraindications: ______________________________

   ____

3. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., nephrologist),or has the prescriber consulted with a specialist in the area of the patient's diagnosis? ☐ Yes ☐ No

4. Is the patient's age within FDA labeling for the requested indication? ☐ Yes ☐ No

   If no, please provide support for using the requested agent for the patient's age for the requested indication: __________

   ____

5. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** ______________________________

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Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

- **Please submit chart notes to support your answers to the following questions:**

6. Has the patient tried and had an inadequate response to Cystagon (immediate release cysteamine)?............... ☐ Yes ☐ No
7. Was Cystagon (immediate release cysteamine) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .... ☐ Yes ☐ No
8. Does the patient have an intolerance or hypersensitivity to Cystagon (immediate release cysteamine) that is not expected to occur with the requested agent? .... ☐ Yes ☐ No
9. Does the patient have an FDA labeled contraindication to Cystagon (immediate release cysteamine) that is not expected to occur with the requested agent? .... ☐ Yes ☐ No
10. Is Cystagon (immediate release cysteamine) expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? .... ☐ Yes ☐ No
11. Is Cystagon (immediate release cysteamine) not in the best interest of the patient based on medical necessity?............... ☐ Yes ☐ No
12. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as Cystagon (immediate release cysteamine) and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .... ☐ Yes ☐ No

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road Suite 200
Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
BCBSIL: 800.285.9426
BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

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