AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: (Check applicable drug below)

❑ **Cystaran®** (cysteamine 0.44%) **ophthalmic solution**	❑ **Cystadrops®** (cysteamine 0.37%) **ophthalmic solution**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Quantity Limits: Maximum approval of 4 bottles (15mL x 4) per 28 days for Cystaran®. Maximum approval of 4 bottles (5mL x 4) per 28 days for Cystadrops®.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial authorization: 6 months

❑ Provider is an ophthalmologist or metabolic geneticist

AND

(Continued on next page)

- ❑ Member has a diagnosis of cystinosis confirmed by the presence of increased cystine concentration in leukocytes OR by genetic testing confirming biallelic pathogenic variants of the CTNS gene with corneal cystine crystal accumulation **(submit labs or genetic test results confirming the member's diagnosis)**

AND

- ❑ Member is receiving concomitant therapy with an oral cysteamine product (e.g., Cystagon, Procysbi)

AND

- ❑ For Cystaran®: Member has a photo-rated Corneal Cystine Crystal Score (CCCS) of ≥ 1.25 units at baseline **(submit slit lamp examination results with score)**
- ❑ For Cystadrops®: Member's baseline corneal cystine crystal density has been assessed by in vivo confocal microscopy (IVCM) **(submit IVCM examination results with score)**

Reauthorization Approval: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member continues to meet all of the initial authorization criteria

AND

- ❑ For Cystaran®: Member has had a reduction of ≥ 1 unit in the photo-rated Corneal Cystine Crystal Score (CCCS) from baseline score OR has maintained a score that is ≥ 1 unit below the baseline score **(submit current slit lamp examination results with score)**
- ❑ For Cystadrops®: Member has had at least a 30% reduction in corneal cystine crystal density as assessed by in vivo confocal microscopy (IVCM) **(submit current IVCM examination results with score)**

Medication being provided by a Specialty Pharmacy - PropriumRx

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

***Approved by Pharmacy and Therapeutics Committee:** 1/21/2021
REVISED/UPDATED: ~~6/30/2021;10/11/2021;~~ **10/27/2023**