Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health
Cysteamine Products – Medical Necessity Request
****Complete page 1 for New/Initial Requests****

Diagnosis Information (please indicate diagnosis and answer related questions):

□ Nephropathic cystinosis

□ Other, please specify _____

General Questions:

1. Does the member have a white blood cell (WBC) cystine level >2 nmol half cystine/mg protein ?? _____
2. Does the member have mutations in the CTNS gene? **Yes or No**
3. Is the medication prescribed by or in consultation with a nephrologist or ophthalmologist? **Yes or No**
4. Will the member be using Cystagon and Procysbi together?? **Yes or No**
5. Does the member have any contraindications to treatment (e.g. allergy to penicillamine)? **Yes or No**
6. **Also for Procysbi requests** Has the member tried cysteamine bitartrate (Cystagon)?

□ **Yes**
a. Why was cysteamine bitartrate (Cystagon) discontinued? _____

□ **No**
a. Would the prescriber consider prescribing cysteamine bitartrate (Cystagon)? **Yes or No**
- If **Yes**, please call the prescription for Cystagon into the pharmacy then complete and fax this form to Horizon NJ Health.
- If **No**, please provide clinical reasoning why Cystagon cannot be tried. _____

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

****Complete this page ONLY for subsequent (renewal) requests****

1. Is the member responding to therapy (e.g., improvement, stabilization, or slowing of disease progression for serum creatinine, calculated creatinine clearance, or leukocyte cystine concentration)? **Yes or No**

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**