Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Cystagon

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Request type:

☐ Initial Therapy - Go to 2 ☐ Continuation of Therapy - Go to 4

Q2. Does the patient have a diagnosis of cystinosis confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing?

☐ Yes ☐ No

Q3. Will Cystagon be used in combination with Procysbi?

☐ Yes ☐ No

Q4. For reauthorization, do lab results or chart notes document a positive response to therapy (e.g., improvement, stabilization, or slowing of disease progression for serum creatinine, calculated creatinine clearance, leukocyte cystine concentration, or maintained growth [height])?

☐ Yes ☐ No

Q5. Additional Information:

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Patient Name:	**Prescriber Name:**

Prescriber Signature

Date

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