Cystaran™ (cysteamine ophthalmic solution) 0.44% PRESCRIPTION & ENROLLMENT FORM

❑ New patient
❑ Current

1 PATIENT INFORMATION

Patient name _____

Date of birth _____ ❑ Male ❑ Female Last 4 digits of SSN _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Parent/guardian (if applicable) _____ ❑ Principle contact

Home phone _____ Work phone _____

Cell phone _____ Evening phone _____

E-mail address _____

Insurance company name _____

Insurance company phone # _____

Insured name _____

Insured employer _____

Relationship to patient _____

Identification # _____ Policy/group # _____

Prescription card ❑ No ❑ Yes If yes, carrier _____

Policy # _____ Group # _____

Is patient eligible for Medicare? ❑ No ❑ Yes

Is patient eligible for Medicaid? ❑ No ❑ Yes

Please attach copy of front and back of patient's insurance cards, if available.

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____

Prescriber name and title _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____

License # _____

DEA #/NPI # _____

Physician Medicaid UPIN # _____

MD specialty _____

To reach your team, call (toll-free) 1 800 440-0473.

Please fax completed form to 1 877 328-9691.

3 CLINICAL INFORMATION

Primary ICD-9/ICD-10 code: 270.0 Cystinosis

Other _____

Other drugs used to treat the disease _____

❑ NKDA ❑ Known drug allergies _____

4 PRESCRIBING INFORMATION

Cystaran (cysteamine ophthalmic solution) 0.44%

Minimum dispense is 1 shipper containing 4 bottles of 15-mL *Cystaran*.

Quantity _____ Days supply _____ Strength _____

Dosage:

Instill 1 drop in each eye every waking hour.

Other instructions _____

_____

Refills _____

Storage:
Store in freezer at –25°C to –15°C (–13°F to 5°F). Thaw for approximately 24 hours before use. Store thawed bottle at 2°C to 25°C (36°F to 77°F) for up to 1 week. Do not refreeze. Discard after 1 week of use.

Shipping instructions:

Deliver product to: ❑ Patient home

New York prescribers, please submit prescription on an original New York state prescription blank. For all other states, if not faxed, must be on state-specific blank, if applicable for your state.

Faxes will only be accepted from a doctor's office.

Class II medications cannot be faxed.

By signing below, I certify that the above therapy is medically necessary.

Physician printed name _____

Physician signature _____ **Date** _____

(No stamps) (Dispense as written)

Physician signature _____ **Date** _____

(No stamps) (Substitutions permitted)

This prescription is valid only if transmitted by means of a facsimile machine.

accredo®