Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Cuprimine® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Cystinuria
- ❑ Severe active rheumatoid arthritis
- ❑ Wilson's disease
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

For cystinuria, answer the following:

Select if Cuprimine is prescribed by or in consultation with the following specialist:

- ❑ Metabolic geneticist
- ❑ Nephrologist

Does the patient have urinary cysteine excretion of > 300 mg/day? ❑ **Yes** ❑ **No**

Select if the patient has had failure following a trial of 30 days, contraindication, or intolerance to the following:

- ❑ Potassium citrate or other urinary alkalinizing agent
- ❑ Sodium and protein-restricted diet
- ❑ Hyperdiuresis (urine output of at least 3 L/day)

Will patient's Cuprimine dose exceed 4 g/day? ❑ **Yes** ❑ **No**

Reauthorization:

Does the patient have urinary cystine excretion of < 200 mg/day? ❑ **Yes** ❑ **No**
Laboratory value of the above must be submitted for documentation

Will patient's Cuprimine dose exceed 4 g/day? ❑ **Yes** ❑ **No**

For severe active rheumatoid arthritis, answer the following:

Is Cuprimine prescribed by or in consultation with a rheumatologist? ❑ **Yes** ❑ **No**

Select if the patient has had failure following a trial of 30 days, contraindication, or intolerance to the following:

- ❑ Cimzia
- ❑ Humira
- ❑ Simponi

Will patient's Cuprimine dose exceed 250 mg/day for the first month and 1.5 g/day for maintenance therapy? ❑ **Yes** ❑ **No**

Reauthorization:

Has the patient shown a clinically significant improvement in rheumatoid arthritis symptoms? ❑ **Yes** ❑ **No**
Chart notes for the above must be submitted for documentation

Will patient's Cuprimine dose exceed 1.5 g/day for maintenance therapy? ❑ **Yes** ❑ **No**

Cuprimine® Prior Authorization Request Form (Page 2 of 2)

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For Wilson's disease, answer the following:

Select if Cuprimine is prescribed by or in consultation with the following specialist:

- ❑ Gastroenterologist
- ❑ Hepatologist

Select if patient's diagnosis of Wilson's disease was confirmed by the following:

- ❑ Presence of Kayser-Fleisher rings
- ❑ Serum ceruloplasmin (CPN) < 20 mg/dL
- ❑ 24-hour urine copper > 40 mcg
- ❑ Liver biopsy with copper dry weight > 250 mcg/g

Laboratory values or chart notes of the above must be submitted for documentation

Will patient's Cuprimine dose exceed 1.5 g/day? ❑ **Yes** ❑ **No**

Reauthorization:

Is the patient's serum copper level < 10 mcg free copper/dL? ❑ **Yes** ❑ **No**

Laboratory value of the above must be submitted for documentation

Will patient's Cuprimine dose exceed 1.5 g/day? ❑ **Yes** ❑ **No**

****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.

Prescriber Signature: _____ **Date:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.