US Family Health Plan
Prior Authorization Request Form for
tiopronin immediate-release (**Thiola**),
tiopronin delayed-release tablets (**Thiola EC**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the patient GREATER THAN or EQUAL to 9 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Is the requested medication being prescribed by or in consultation with a nephrologist or urologist?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Does the patient have a document diagnosis of severe homozygous cystinuria?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Is there laboratory evidence of elevated urinary cysteine concentration (greater than 250 mg/L) as demonstrated by a 24-hour urine test?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved

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5. Has the patient tried and failed ALL of the following therapies: • **high fluid intake greater than or equal to 3L/day** • **urinary alkalization with potassium citrate or potassium bicarbonate** • **diet modification with restricted protein and sodium consumption?**	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.**
Please sign and date:

Prescriber Signature _____ Date _____

[19 February 2020]