# Prior Authorization Request Form for

tiopronin immediate-release **(Thiola),**
tiopronin delayed-release tablets **(Thiola EC)**

JOHNS HOPKINS MEDICINE
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**FAX Completed Form and Applicable Progress Notes to: (410) 424-4037**

## USFHP Pharmacy Prior Authorization Form

| To be completed by Requesting provider | |
|---|---|
| Drug Name: | Strength: |
| Dosage/Frequency (SIG): | Duration of Therapy: |

***Questions?*** Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

**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<br>Proceed to question **2** | ☐ No<br>**STOP**<br>Coverage not approved |
| **2. Is the requested medication being prescribed by or in consultation with a nephrologist or urologist?** | ☐ Yes<br>Proceed to question **3** | ☐ No<br>**STOP**<br>Coverage not approved |
| **3. Does the patient have a document diagnosis of severe homozygous cystinuria?** | ☐ Yes<br>Proceed to question **4** | ☐ No<br>**STOP**<br>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<br>Proceed to question **5** | ☐ No<br>**STOP**<br>Coverage not approved |

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| | | |
|---|---|---|
| **5. Has the patient tried and failed ALL of the following therapies:**<br>• **high fluid intake greater than or equal to 3L/day**<br>• **urinary alkalization with potassium citrate or potassium bicarbonate**<br>• **diet modification with restricted protein and sodium consumption?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>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]

| **For Internal Use Only** | |
|---|---|
| ☐ Approved: | Duration of Approval: _____month(s) |
| ☐ Denied: | Authorized By: |
| ☐ Incomplete/Other: | PA#: |
| Date Faxed to MD: | Date Decision Rendered: |