PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

# **Cystaran** (cysteamine ophthalmic solution) 0.44%

**Prescription & enrollment form**

☐ New patient ☐ Current patient

Note: This form is intended for prescriber use only.
If faxed, the fax must come from MD office or hospital (should not be faxed by patient).

## Patient information (Include the front and back copy of the patient's insurance card)

Patient name _____
Date of birth _____ ☐ Male ☐ Female
Street address _____
City _____ State _____ ZIP _____
Parent/guardian (if applicable) _____ ☐ Principle contact
Home phone _____ Work phone _____
Cell phone _____ Evening phone _____
Email 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 # _____
Eligible for Medicare? ☐ No ☐ Yes Eligible for Medicaid? ☐ No ☐ Yes

## Prescriber information

Date _____ Time _____
Prescriber name _____
Prescriber practice title _____
Street address _____
City _____ State _____ ZIP _____
Phone _____ Fax _____
License # _____ DEA # _____
Physician Medicaid UPIN # _____ NPI# _____
MD specialty _____

## Clinical information

ICD-10 code: _____
Secondary ICD-10: _____ Other _____
Other drugs used to treat the disease _____
☐ NKDA ☐ Known drug allergies _____

## Prescribing information

Cystaran (cysteamine ophthalmic solution) 0.44%
Dosage:
☐ Instill one drop in each eye every waking hour
☐ Alternate instructions (Please place alternate directions below)

_____
_____

Minimum dispense is one shipment containing 4 bottles of 15 mL Cystaran.
Dispense:
____ 1-month supply (4 bottles) ____ 3-month supply (12 bottles) ____ Refills
Shipping instructions: _____
Deliver product to: ☐ Patient home ☐ Other

## Prescriber signature

**By signing below, I certify that the prescribed 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 directly from the prescriber's office or place of practice.

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. Drug names are the property of their respective owners.

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