BlueCross BlueShield Federal Employee Program

TIOPRONIN
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Tiopronin / Tiopronin delayed release tablets

NOTE: Form must be completed in its **entirety** for processing

Please select medication: ❑**Thiola (tiopronin)** ❑**Thiola EC (tiopronin delayed release tablets)**

***Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. Does the patient have a diagnosis of homozygous cystinuria? ❑Yes ❑No
2. Will Thiola be used in combination with high fluid intake, alkali, and diet modification? ❑Yes ❑No
3. What is the patient's weight? _____ kg **OR** _____ lbs
4. Has the patient been on Thiola continuously for the last **6 months**, excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

a. Does the patient have severe homozygous cystinuria? ❑Yes ❑No

b. Has the diagnosis been confirmed by genetic testing? ❑Yes ❑No

c. Is Thiola being used for prevention of cystine stones? ❑Yes ❑No

d. Have pretreatment baseline cystine levels been obtained or will be obtained? ❑Yes ❑No

e. Does the prescriber agree to monitor cystine levels one month after initiation of treatment and every three months thereafter? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

a. Has the patient experienced a decrease in urinary cystine levels and cystine stone formation compared to pretreatment baseline? ❑Yes ❑No

b. Does the prescriber agree to monitor cystine levels every three months? ❑Yes ❑No