anovo
SPECIALTY PHARMACY

Fax: 855-813-2039
Phone: 866-925-6212

CYSTADROPS®
(cysteamine ophthalmic solution) 0.37%
Prescription Order Form

Please select one: ☐ **Newly Prescribed Patient** ☐ **Patient Currently on Cystadrops®**

Patient Information **Please print*

Last Name: First Name:		SSN:	Sex: ◯M ◯F
Address:	City:	State:	Zip:
Phone: Day #	Evening #:	Cell # :	
DOB:			
If Patient is a Minor, Guardian/Parent Name:		Relation to Patient:	
Emergency Contact:		Phone #:	

Insurance Information **Include copies of insurance cards*

Primary Insurance Co. Name:		Phone #:
Policy Holder Name:	Policy #:	Group #:
Prescription Card Name:		Phone #:
Policy #:		Group #:
Secondary Insurance Co. Name:		Phone #:
Policy Holder Name:	Policy #:	Group #:

Physician Information

Prescriber Name/Title:			
NPI:	DEA:	Medicaid UPIN:	State License #:
Address:			
City:	State:	Zip:	
Name of Contact Person:			Phone:
Physician Email:			Fax:

Prescription

CYSTADROPS® (cysteamine ophthalmic solution) 0.37%

Sig: _____ drop(s) in each eye four times a day. Do not touch dropper to eye. Discard unused portion after 7 days.

PLEASE NOTE: Minimum dispense is 1 shipment containing 4 bottles of Cystadrops

Dispense ☐ 1-month supply (4 bottles) ☐ 3-month supply (12 bottles)

Refills _____

Medical Necess

Primary diagnosis:	Date of Diagnosis :	Patient Age at Diagnosis:

Please check applicable ICD-10 code:

☐ Cystinosis (E72.04)

Therapy Start Date:

Allergies ☐ NKDA

I certify I am prescribing CYSTADROPS® for this patient for a medically necessary purpose. **Date Written:** _____

Dispense as Written: _____
(Stamped Signatures Are Not Valid)

Substitution Allowed: _____
(Stamped Signatures Are Not Valid)

This Prescription Form is only valid if FAXED to Anovo @ 855-813-2039

Form:CYSDP.RX.01
Effective Date: 9/1/2019
Revision Date:
8/13/2020