Health Partners Plans

**HEALTH PARTNERS PLANS**
***PRIOR AUTHORIZATION REQUEST FORM***

# Tolvaptan (Jynarque & Samsca)

**Phone: 215-991-4300** **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.**

| | | |
|---|---|---|
| Patient Name: | Prescriber Name: | |
| HPP Member Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| Patient Primary Phone: | NPI: | *PA PROMISe ID:* |
| Address: | Address: | |
| City, State ZIP: | City, State ZIP: | |
| Line of Business: ☐ Medicaid ☐ CHIP | *Specialty Pharmacy (if applicable):* | |
| **Drug Name:** | **Strength:** | |
| **Quantity:** | **Refills:** | |
| **Directions:** | | |
| **Diagnosis Code:** | **Diagnosis:** | |
| *HPP's maximum approval time is 12 months but may be less depending on the drug.* | | |

**Please attach any pertinent medical history including labs and information for this member that may support approval.**

***Please answer the following questions and sign.***

Q1. What is the patient's diagnosis?

☐ a. Autosomnal dominant polycystic kidney disease (ADPKD).

☐ b.Hypervolemic and euvolemic hyponatremia, including patients with heart failure and Syndrome of Inappropriate Antidiuretic Hormone (SIADH

Q2. Is the patient greater than or equal to 18 years of age?

☐ Yes ☐ No

Q3. Has genetic testing been completed with positive results for known mutations OR is there a confirmed family history of mutation showing abnormality on chromosome 16 (PKD1) OR chromosome 4 (PKD2) OR other gene mutation confirming diagnosis with a renal ultrasound, MRI or CT of adult dominant polycystic kidney disease? (results must be attached).

☐ Yes ☐ No

Q4. For patients without a family history of ADPKD OR genetic testing has not been done: Has a renal ultrasonography been completed, with results showing 10 or more cysts (greater than or equal to 5 mm) in each kidney AND other acquired renal disorders have been ruled out (chart notes and results must be attached)?

☐ Yes ☐ No

Q5. Has the patient been identified as high risk for rapid progression with an estimated glomerular filtration rate (eGFR) ≥25mL/min1.73 m2 AND one of the following: A. Identified as high risk with the Mayo Classification system for progression to end-stage renal disease classes: 1C, 1D OR 1E.; B. Age ≤55 years and an eGFR <65 mL/min/1.73 m2; C. Average kidney length (by ultrasound, magnetic resonance imaging [MRI], or computed tomography [CT]) >16.5 cm in a patient aged <50 years; D. PROPKD score >6 in patients who have genetic data available I. Low risk: PROPKD score 0 to 3 points II. Intermediate risk: PROPKD score 4 to 6 points
III. High Risk: PROPKD score 7 to 9 points

Health Partners Plans

**HEALTH PARTNERS PLANS**
***PRIOR AUTHORIZATION REQUEST FORM***

# Tolvaptan (Jynarque & Samsca)

**Phone: 215-991-4300** **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.**

| Patient Name: | Prescriber Name: |
|---|---|

☐ Yes ☐ No

Q6. Is the initial dose and titration plan in line with FDA approved recommended dosage (initial 60 mg per day given as 45 mg taken on waking and 15 mg 8 hours later) and titration (per patient response and tolerability at 7 day intervals between titrations (90 mg/ day in divided doses (given as 60 mg upon waking then 30 mg 8 hours later) followed by 120 mg/day (given as 90 mg upon waking and 30 mg 8 hours later))?

☐ Yes ☐ No

Q7. Are baseline (within last 30 days of initiation) labs attached (hepatic transaminases, bilirubin, serum sodium level, eGFR)? Documentation must be attached.

☐ Yes ☐ No

Q8. Will labs (hepatic transaminases, bilirubin and serum sodium levels) be monitored 2 and 4 weeks after initiation? Documentation must be attached.

☐ Yes ☐ No

Q9. Is the patient enrolled in the Jynarque REMS program and agreed to comply with all monitoring requirements?

☐ Yes ☐ No

Q10. Has the patient been informed of the risk of hepatoxicity and dehydration and counseled on how to recognize signs and symptoms of hepatotoxicity (such as fatigue, anorexia, nausea, right upper abdominal discomfort, vomiting, fever, rash, pruritis, dark urine or jaundice) and dehydration (tachycardia, hypotension, weight loss) and aware of the appropriate action to take if these symptoms occur?

☐ Yes ☐ No

Q11. Has Samsca been initiated or being reinitiated in a hospital?

☐ Yes ☐ No

Q12. Are labs (liver enzymes, bilirubin, serum sodium) attached and plan to be monitored along with symptoms of liver injury (eg, fatigue, anorexia, right upper quadrant discomfort, dark urine, jaundice). Documentation must be attached.

☐ Yes ☐ No

Q13. Is the duration of therapy limited to 30 days of treatment?

☐ Yes ☐ No

Q14. Additional Information:

Prescriber Signature

Date

Health Partners Plans

**HEALTH PARTNERS PLANS**
***PRIOR AUTHORIZATION REQUEST FORM***

# Tolvaptan (Jynarque & Samsca)

**Phone: 215-991-4300** **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.**

| Patient Name: | Prescriber Name: |
|---|---|

*Updated for 2023*