PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Tolvaptan

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health 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:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: ☐ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

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?

☐ Autosomal dominant polycystic kidney disease (ADPKD). Go to 2.

☐ Hypervolemic and euvolemic hyponatremia, including patients with heart failure and Syndrome of Inappropriate Antidiuretic Hormone (SIADH). Go to 8

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

☐ Yes ☐ No

Q3. Is the prescriber in consultation with a nephrologist or appropriate specialist?

☐ Yes ☐ No

Q4. Is there confirmation of the diagnosis of ADPKD via: genetic testing, renal ultrasound, MRI or CT scan (results must be attached)?

☐ Yes ☐ No

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Q5. Has the patient been identified as high risk for rapid progression of ADPKD with one of the following?

a. Mayo Classification defined as high risk for progression to end-stage renal disease class: 1C, 1D OR 1E.
b. A Predicting Renal Outcome in Polyscystic Kidney Disease (PROPKD) score greater than 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

☐ Yes ☐ No

Q6. Is the initial dose and titration plan in line with FDA approved recommended dosage and titration schedule?

☐ Yes ☐ No

Q7. Are baseline labs attached (AST, ALT, and bilirubin) and plan to be monitored? Labs must be attached.

☐ Yes ☐ No

Q8. Has tolvaptan been initiated or being reinitiated in a hospital?

☐ Yes ☐ No

Q9. Are labs (AST, ALT, bilirubin, serum sodium levels) attached and plan to be monitored?

☐ Yes ☐ No

Q10. Is the duration of therapy limited to 30 days of treatment?

☐ Yes ☐ No

Q11. Additional Information:

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Patient Name:	**Prescriber Name:**

____ ______________________________

Prescriber Signature Date

v2025

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