REALRx

PRIOR AUTHORIZATION REQUEST FORM
VASOPRESSIN RECEPTOR ANTAGONISTS
Jynarque®, Samsca®

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements..

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Jynarque® (tolvaptan), ☐ tolvaptan tablets
Non-preferred: ☐ Samsca® (tolvaptan)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.			
Questions	**Yes**	**No**	**Comments/Notes**
1. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
AUTOSOMAL DOMINANT POLYCYSTIC KIDNEY DISEASE (ADPKD)			
1. Is the member 18 years of age or older?	☐	☐	
2. Is the requesting prescriber a nephrologist?	☐	☐	

3. Does the member have a documented diagnosis of ADPKD confirmed by both of the following:
• A mutation in the PKD1 or PKD2 gene
• Diagnosis by modified Pei-Ravine criteria
  • with family history: 3 cysts if by sonography, 5 cysts if by CT or MRI
  • without family history: 10 cysts per kidney
	☐	☐	**Please provide documentation**

4. Is the member at high risk for rapidly-progressing disease determined by one of the following: • Total kidney volume (TKV) ≥ 750mL • MAYO classification of 1C, 1D, or 1E • Kidney length > 16.5cm • Predicting Renal Outcomes (PROPKD) in ADPKD score ≥ 7	☐	☐	**Please provide documentation**

• Sustained decline in renal function (continued decrease in eGFR) • Sustained increase in TKV ≥ %5 per year			
5. Does the member have CKD stage 2-3 determined by two blood tests over 72 hours apart?	☐	☐	**Please provide documentation**
6. Has a comprehensive metabolic panel been complete at baseline?	☐	☐	**Please provide documentation**
7. Does the provider confirm that there are no significant interacting drugs (CYP 3A drugs) with Jynarque®?	☐	☐	
HYPONATREMIA			
1. Is the requesting prescriber a nephrologist or in consultation with one?	☐	☐	
2. Has the member been diagnosed with hypervolemic or euvolemic hyponatremia?	☐	☐	**Please provide documentation**
3. Does the member have a serum sodium level < 125mEq/L or a serum sodium level of 125-134mEq/L that is symptomatic?	☐	☐	**Please provide documentation**
4. Was tolvaptan therapy initiated in the hospital?	☐	☐	
5. Does the member have failure, contraindication, or intolerance that makes them unable to use therapies (e.g. fluid restriction, loop diuretics, saline infusion) to control hyponatremia?	☐	☐	**Please provide documentation**
6. Does the provider confirm that there are no significant interacting drugs (CYP 3A drugs) with tolvaptan?	☐	☐	
REAUTHORIZATION			
JYNARQUE®			
1. Is the request for reauthorization of Jynarque®?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 3 months?	☐	☐	
3. Does the provider attest that the member's kidney disease progression is declining?	☐	☐	**Please provide documentation**
4. Has a recent comprehensive metabolic panel been completed?	☐	☐	**Please provide updated comprehensive metabolic panel**
tolvaptan			
1. Is the request for reauthorization of tolvaptan?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 30 days?	☐	☐	
3. Does the member meet the initial criteria?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			

Additional information:
Physician Signature:

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Policy PHARM-085
Origination Date: 09/04/2019
Reviewed/Revised Date: 03/15/2023
Next Review Date: 03/15/2024
Current Effective Date: 04/01/2023