Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Jynarque (tolvaptan) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Jynarque (tolvaptan)** for **Commercial, Exchange, FEHB (Federal),** and **MD Medicaid** plans. Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103.

Requests will not be considered unless this form is complete.

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Is the prescriber a nephrologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Provider Name: _____ Specialty: _____ NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Member is ≥18 years and <56 years**,**
   □ No □ Yes

2. **AND** eGFR >25 mL/min/1.73 m^2,
   □ No □ Yes

3. **AND** baseline labs completed within 30 days and within normal limits: ALT, AST, bilirubin; and negative pregnancy test (if applicable),
   □ No □ Yes

4. **AND** member has a diagnosis of autosomal dominant polycystic kidney disease (ADPKD) confirmed by one of the following:
   - Ultrasonography:
     - With family history: ≥3 cysts (unilateral or bilateral) in patients aged 15-39 years OR ≥2 cysts in each kidney in patients aged 40-59 years
     - Without family history: ≥10 cysts per kidney
   - **OR** Magnetic resonance imaging (MRI) or computed tomography (CT) scan:
     - With family history: ≥5 cysts per kidney
     - Without family history: ≥10 cysts per kidney

   □ No □ Yes

5. **AND** high risk of disease progression defined by one of the following:
   - Mayo ADPKD Classification 1C, 1D, or 1E
   - eGFR decline ≥5 mL/min/1.73 m^2 in one year OR eGFR decline ≥2.5 mL/min/1.73 m^2 per year over a period of ≥5 years
   - Truncating PKD1 mutation AND PROPKD score >6

   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below. New members who were initiated on therapy outside of Kaiser, who have not been reviewed previously, must meet all above Clinical Criteria.

1. Member has positive clinical response to tolvaptan,
   No □ Yes

2. **AND** member's eGFR >25 mL/min/1.73 m^2,
   No □ Yes

3. **AND** member has followed up with a nephrologist within the last 12 months
   No □ Yes

7 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**