Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Jynarque (tolvaptan) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 6 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Jynarque (tolvaptan)** for **VA 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

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. Does the patient have a diagnosis of autosomal dominant polycystic kidney disease (ADPKD)?
   □ No □ Yes

2. Is the patient 18 years of age or older?
   □ No □ Yes

3. Does the patient have ANY of the following (therapy will not be approved if so)?
   a. History of signs or symptoms of significant liver impairment or injury (not including uncomplicated polycystic liver disease)
   b. Uncorrected abnormal blood sodium concentrations
   c. Hypovolemia
   d. Uncorrected urinary outflow obstruction
   e. Anuria
   □ No □ Yes

4. Is the provider certified through the Jynarque REMS program?
   □ No □ Yes

5. Is the patient enrolled in the Jynarque REMS program, and has been educated on the risk of hepatotoxicity?
   □ No □ Yes

6. Does the patient have concurrent use of strong CYP3A inhibitors (therapy will not be approved if so)?
   □ No □ Yes

7. Have baseline alanine aminotransferase (ALT), aspartate aminotransferase (AST) and bilirubin tests been performed?
   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below.

1. Does the patient continue to meet the above initial criteria?
   □ No □ Yes

2. Are the most recent ALT, AST, and bilirubin ALL within normal range and checked within 3 months of the renewal request?
   □ 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:**