Jefferson Health Plans

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 (within 30 days of initiation) attached (AST, ALT, and bilirubin) and within normal limits? If labs are above the upper limit of normal is there documentation attached supporting safe initiation of Jynarque? Labs must be attached.

☐ Yes ☐ No

Q8. Will labs (AST, ALT, and bilirubin) continue to be monitored for the first 18 months of treatment?

☐ Yes ☐ No

Q9. Has Samsca been initiated or being reinitiated in a hospital?

☐ Yes ☐ No

Q10. Are labs (AST, ALT, bilirubin, serum sodium levels) attached and plan to be monitored?

☐ Yes ☐ No

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Q11. Is the duration of therapy limited to 30 days of treatment?

☐ Yes ☐ No

Q12. If the request is for a brand agent with an available generic equivalent: (select all that apply)

☐ The patient has an intolerance, hypersensitivity, or contraindication to the generic drug that is not expected to occur with the brand drug (chart notes/medical records required);

☐ There is support for the use of the non-formulary drug over the therapeutically equivalent formulary drug (chart notes/medical records required).

Q13. Additional Information:

Prescriber Signature

Date

v2026