HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Tolvaptan - Non-PDL

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners 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.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

HPP's maximum approval time is 12 months but may be less depending on the drug.

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. Is this a renewal request? If YES, please go to 13.

☐ Yes ☐ No

Q2. What is the patient's diagnosis?

☐ Autosomal dominant polycystic kidney disease (ADPKD).

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

Q3. Is the patient greater than or equal to 18 years of age?

☐ Yes ☐ No

Q4. Is the prescriber in consultation with a nephrologist or appropriate specialist?

☐ Yes ☐ No

Q5. 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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Q6. 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

Q7. Is the initial dose and titration plan in line with FDA approved recommended dosage and titration schedule?

☐ Yes ☐ No

Q8. Are baseline (within 30 days of initiation) labs 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

Q9. Will labs (AST, ALT, and bilirubin) continue to be monitored for the first 18 months of treatment?

☐ Yes ☐ No

Q10. Has Samsca been initiated or being reinitiated in a hospital?

☐ Yes ☐ No

Q11. Are labs (AST, ALT, bilirubin, serum sodium levels) attached and plan to be monitored?

☐ Yes ☐ No

Q12. Is the duration of therapy limited to 30 days of treatment?

☐ Yes ☐ No

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Q13. Has the patient been previously approved for Jynarque?

☐ Yes ☐ No

Q14. Has the patient been compliant with therapy?

☐ Yes ☐ No

Q15. Has the patient shown improvement with Jynarque?

☐ Yes ☐ No

Q16. Are recent (within past 3 months) lab results (hepatic transaminases, and bilirubin) within normal range? Documentation must be attached.

☐ Yes ☐ No

Q17. Are AST/ALT or bilirubin levels 2 OR 3 times the upper limit of normal with a plan attached addressing elevated levels and supporting continued use of Jynarque?

☐ Yes ☐ No

Q18. Confirmation that labs (AST, ALT, and bilirubin) will continue to be monitored?

☐ Yes ☐ No

Q19. Additional Information:

_____ _____

Prescriber Signature Date

v2025