Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Tolvaptan - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

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.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	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 applying the 72 hour 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. Is this a reauthorization request? If YES, go to 2. If NO, go to 3.

☐ Yes ☐ No

Q2. Is there confirmation of stabilization or a positive clinical response?

☐ Yes ☐ No

Q3. Is the requested drug being prescribed by or in consultation with an appropriate specialist such as a nephrologist?

☐ Yes ☐ No

Q4. Is the patient 18 years or age or older?

☐ Yes ☐ No

Q5. Is there documentation of a diagnosis of rapidly progressing autosomal dominant polycystic kidney disease (ADPKD)?

☐ Yes ☐ No

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Member Name:	**Prescriber Name:**

Q6. Is the patient's eGFR greater than or equal to 25 mL/min/1.73 m2?

☐ Yes ☐ No

Q7. Does the patient meet one of the following criteria?

☐ Mayo Imaging Classification 1C, 1D, or 1E
☐ Predicting Renal Outcome in Polycystic Kidney Disease [PROPKD] score greater than 6
☐ Family history with onset of kidney replacement therapy at less than 60 years in greater than or equal to 2 first-line family members
☐ Historical rate of eGFR decline of greater than or equal to 3 mL/min/1.73 m2 per year

Q8. If eGFR loss has likely alternative explanations and/or patient has acute kidney injury, is there documentation showing that other acute or chronic causes of eGFR decline have been assessed?

☐ Yes ☐ No

Q9. Requested Duration:

☐ 12 Months ☐ Other:

Q10. Additional Information:

_____ _____

Prescriber Signature Date

v2026