Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Tolvaptan

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.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP: **Specialty/facility name (if applicable):**	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

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. What is the patient's diagnosis?

☐ Autosomnal dominant polycystic kidney disease (ADPKD) ☐ Hypervolemic and euvolemic hyponatremia with SIADH

Q2. Is the patient greater than or equal to 18 years of age?

☐ Yes ☐ No

Q3. Has genetic testing been completed with positive results for known mutations OR is there a confirmed family history of mutation showing abnormality on chromosome 16 (PKD1) OR chromosome 4 (PKD2) OR other gene mutation confirming diagnosis of adult dominant polycystic kidney disease? (results must be attached)

☐ Yes ☐ No

Q4. For patients with gene mutations or a positive family history of gene mutation: Has a renal ultrasonography been completed, with results confirming positive diagnosis in accordance with patient age? (results must be attached):
a. Patients 15-30 years of age with known risk for familial genotype for type 1 ADPKD : at least two unilateral or bilateral cysts
b. Patients 15-39 years of age: at least three unilateral or bilateral kidney cysts.
c. Patients 40-59 years of age: at least two cysts in each kidney.
d. Patients 60 years or older: at least 4 cysts in each kidney

☐ Yes ☐ No

Q5. Has the patient been identified as high risk for rapid progression with an estimated glomerular filtration rate (eGFR)

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Patient Name:	**Prescriber Name:**

≥25mL/min1.73 m2 WITH one of the following:
a. Identified as high risk with the Mayo Classification system for progression to end-stage renal disease classes: 1C, 1D OR 1E.
b. Age ≤55 years and an eGFR <65 mL/min/1.73 m2
c. Kidney length (by ultrasound, magnetic resonance imaging [MRI], or computed tomography [CT]) >16.5 cm in a patient aged <50 years
d. PROPKD score >6 in patients who have genetic data available

☐ Yes ☐ No

Q6. Is the initial dose and titration plan in line with FDA approved recommended dosage (initial 60 mg per day given as 45 mg taken on waking and 15 mg 8 hours later) and titration (per patient response and tolerability at 7 day intervals between titrations (90 mg per day given as 60 mg upon waking then 30 mg 8 hours later)? Titration plan must be attached.

☐ Yes ☐ No

Q7. Are baseline (within last 30 days of initiation) labs attached (CBC, hepatic transaminases, bilirubin, serum sodium level, eGFR, serum sodium level)? Documentation must be attached.

☐ Yes ☐ No

Q8. Will labs (hepatic transaminases, bilirubin and serum sodium levels) be monitored 2 and 4 weeks after initiation? Documentation must be attached.

☐ Yes ☐ No

Q9. Is the patient enrolled in the Jynarque REMS program and agreed to comply with all monitoring requirements?

☐ Yes ☐ No

Q10. Has the patient been informed of the risk of hepatoxicity and dehydration and counseled on how to recognize signs and symptoms of hepatotoxicity (such as fatigue, anorexia, nausea, right upper abdominal discomfort, vomiting, fever, rash, pruritis, dark urine or jaundice) and dehydration (tachycardia, hypotension, weight loss) and aware of the appropriate action to take if these symptoms occur?

☐ Yes ☐ No

Q11. Has Samsca been initiated or being reinitiated in a hospital?

☐ Yes ☐ No

Q12. Are labs (liver enzymes, bilirubin) attached and plan to be monitored along with symptoms of liver injury (eg, fatigue, anorexia, right upper quadrant discomfort, dark urine, jaundice). Documentation must be attached.

☐ Yes ☐ No

Q13. Is the duration of therapy limited to 30 days of treatment?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q14. Requested Duration:

☐ 30 Days

Q15. Additional Information:

Prescriber Signature

Date

Updated 2018