Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Tolvaptan Renewal

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. Has the patient been previously approved for Jynarque?
☐ Yes ☐ No

Q2. Has the patient been compliant with therapy?
☐ Yes ☐ No

Q3. Does the patient have any adverse side effects?
☐ Yes ☐ No

Q4. Are recent labs (within last 30 days, if after 18 months of treatment within last 3 months) attached (hepatic transaminases, bilirubin and serum sodium levels) AND within normal range? Documentation must be attached.
☐ Yes ☐ No

Q5. Are AST/ALT or bilirubin levels 2 OR 3 times the upper limit of normal with a plan attached for treatment suspension?
☐ Yes ☐ No

Q6. Are AST/ALT elevated above baseline (less than 2 times the upper limit of normal) with an attached plan for more frequent monitoring, possible treatment suspension and re-evaluation of liver tests?
☐ Yes ☐ No

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Q7. Are serum sodium levels above normal range OR is the patient dehydrated or hypovolemic and fluid intake cannot be increased? Documentation must be attached.

☐ Yes ☐ No

Q8. Has kidney function worsened? (reduction of serum creatinine, significant kidney pain, increase in albumin/creatinine ratio, increase in blood pressure). Documentation must be attached.

☐ Yes ☐ No

Q9. Requested Duration:

☐ 3 Months

Q10. Additional Information:

Prescriber Signature

Date

Updated 2018