



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Tolvaptan (Jynarque & Samsca) 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.

Form with two columns: Patient Name and Prescriber Name. Fields include HPP Member Number, Date of Birth, Address, City, State ZIP, Patient Primary Phone, Line of Business (Medicaid/CHIP), Fax, Office Contact, NPI, Promise ID, Prescriber PA PROMISe ID, Address, City, State ZIP, and Specialty/facility name (if applicable).

Expedited/Urgent checkbox

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 checkbox

No checkbox

Q2. Has the patient been compliant with therapy?

Yes checkbox

No checkbox

Q3. Does the patient have any adverse side effects?

Yes checkbox

No checkbox

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 checkbox

No checkbox

Q5. Are AST/ALT or bilirubin levels 2 OR 3 times the upper limit of normal with a plan attached for treatment suspension?

Yes checkbox

No checkbox

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 checkbox

No checkbox

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Patient Name:

Prescriber Name:

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 for 2020