Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Jynarque (tolvaptan) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Jynarque (tolvaptan).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: ________________________________ Kaiser Medical ID#: __________________ Date of Birth: ______________

2 – Provider Information

Is the prescriber a nephrologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: ____

Provider Name: ________________________________ Specialty: ____________________________ NPI: ____________________

Provider Address: ____

Provider Phone #: ___________________________Provider Fax #: ____________________________

3 – Pharmacy Information

Pharmacy Name: __________________________________ Pharmacy NPI: ____

Pharmacy Phone #_________________________________ Pharmacy Fax #: ____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: ____

Sig: ____

Drug 2: Name/Strength/Formulation: ____

Sig: ____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: ___________________________________
2. Indicate the patient's diagnosis for the requested medication: ____

Clinical Criteria:

1. Member is ≥18 years and <56 years**,**
   □ No □ Yes

2. **AND** eGFR >25 mL/min/1.73 m^2,
   □ No □ Yes

3. **AND** baseline labs completed within 30 days and within normal limits: ALT, AST, bilirubin; and negative pregnancy test (if applicable),
   □ No □ Yes

4. **AND** member has a diagnosis of autosomal dominant polycystic kidney disease (ADPKD) confirmed by one of the following:
   - Ultrasonography:
     - With family history: ≥3 cysts (unilateral or bilateral) in patients aged 15-39 years OR ≥2 cysts in each kidney in patients aged 40-59 years
     - Without family history: ≥10 cysts per kidney
   - **OR** Magnetic resonance imaging (MRI) or computed tomography (CT) scan:
     - With family history: ≥5 cysts per kidney
     - Without family history: ≥10 cysts per kidney

   □ No □ Yes

5. **AND** high risk of disease progression defined by one of the following:
   - Mayo ADPKD Classification 1C, 1D, or 1E
   - eGFR decline ≥5 mL/min/1.73 m^2 in one year OR eGFR decline ≥2.5 mL/min/1.73 m^2 per year over a period of ≥5 years
   - Truncating PKD1 mutation AND PROPKD score >6

   □ No □ Yes

For continuation of therapy, please respond to additional questions below:

1. Member has positive clinical response to tolvaptan,
   □ No □ Yes

2. **AND** member's eGFR >25 mL/min/1.73 m^2,
   □ No □ Yes

3. **AND** member has followed up with a nephrologist within the last 12 months
   □ No □ Yes

7 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

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I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**
Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility	