US Family Health Plan
Prior Authorization Request Form for
tolvaptan (**Jynarque**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1

Please complete patient and physician information (please print):

Patient Name: ____________________ Physician Name: ____________________
Address: ____________________ Address: ____________________
____________________ ____________________
Sponsor ID # ____________________ Phone #: ____________________
Date of Birth: ____________________ Secure Fax #: ____________________

Step 2

Please complete clinical assessment:

Question	Yes	No
1. Does the provider acknowledge that Jynarque requires liver function monitoring with evaluation of transaminases and bilirubin before initiating treatment, at 2 weeks and 4 weeks after initiation, then continuing monthly for the first 18 months and every 3 months thereafter?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is Jynarque being prescribed by or in consultation with a nephrologist?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have rapidly progressing autosomal dominant polycystic kidney disease (ADPKD, defined as reduced or declining renal function [i.e., glomerular filtration rate (GFR) less than or equal to 65 mL/min/1.73 m2] and high total kidney volume [i.e., greater than or equal to 750ml])?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have Stage 5 chronic kidney disease (CKD) [GFR less than 15 mL/min/1.73 m2]?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 6**
6. Is the patient receiving dialysis?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 7**

7. **Is the patient currently taking Samsca (tolvaptan)?**	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_______________________________________ _____________

Prescriber Signature Date

[28 November 2018]