



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Tolvaptan - Non-PDL

Phone: 866-841-7659

Fax back to: 866-240-3712

Jefferson Health 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.

Member Name:		Prescriber Name:	
Member ID Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Phone Number:	NPI:	PA PROMISe ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..</i>			

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. Is this a renewal request? If YES, please go to 13.

Yes

No

Q2. What is the patient's diagnosis?

Autosomal dominant polycystic kidney disease (ADPKD).

Hypervolemic and euvolemic hyponatremia, including patients with heart failure and Syndrome of Inappropriate Antidiuretic Hormone (SIADH).

Q3. Is the patient greater than or equal to 18 years of age?

Yes

No

Q4. Is the prescriber in consultation with a nephrologist or appropriate specialist?

Yes

No

Q5. Is there confirmation of the diagnosis of ADPKD via: genetic testing, renal ultrasound, MRI or CT scan (results must be attached)?

Yes

No

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Q6. Has the patient been identified as high risk for rapid progression of ADPKD with one of the following?

a. Mayo Classification defined as high risk for progression to end-stage renal disease class: 1C, 1D OR 1E.

b. A Predicting Renal Outcome in Polycystic Kidney Disease (PROPKD) score greater than 6 in patients who have genetic data available

i. Low risk: PROPKD score 0 to 3 points

ii. Intermediate risk: PROPKD score 4 to 6 points

iii. High Risk: PROPKD score 7 to 9 points

Yes No

Q7. Is the initial dose and titration plan in line with FDA approved recommended dosage and titration schedule?

Yes No

Q8. Are baseline (within 30 days of initiation) labs attached (AST, ALT, and bilirubin) and within normal limits; if labs are above the upper limit of normal is there documentation attached supporting safe initiation of Jynarque? Labs must be attached.

Yes No

Q9. Will labs (AST, ALT, and bilirubin) continue to be monitored for the first 18 months of treatment?

Yes No

Q10. Has Samsca been initiated or being reinitiated in a hospital?

Yes No

Q11. Are labs (AST, ALT, bilirubin, serum sodium levels) attached and plan to be monitored?

Yes No

Q12. Is the duration of therapy limited to 30 days of treatment?

Yes No



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Q13. Has the patient been previously approved for Jynarque?

Yes No

Q14. Has the patient been compliant with therapy?

Yes No

Q15. Has the patient shown improvement with Jynarque?

Yes No

Q16. Are recent (within past 3 months) lab results (hepatic transaminases, and bilirubin) within normal range? Documentation must be attached.

Yes No

Q17. Are AST/ALT or bilirubin levels 2 OR 3 times the upper limit of normal with a plan attached addressing elevated levels and supporting continued use of Jynarque?

Yes No

Q18. Confirmation that labs (AST, ALT, and bilirubin) will continue to be monitored?

Yes No

Q19. Additional Information:

Prescriber Signature

Date

v2026-06