OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization may be delayed.**

Drug Requested: Samsca® (tolvaptan)

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Prescriber is an Endocrinologist or Nephrologist

AND

- ❑ Member has an indication of hypervolemic or euvolemic hyponatremia that has failed to respond to fluid restriction

AND

- ❑ Serum sodium levels obtained and measured to be <125mEq/L , **OR** member has less marked hyponatremia that is symptomatic **(documentation with recorded laboratory results and/or chart notes MUST accompany request)**

AND

- ❑ The member does not have any signs/symptoms of hepatic injury **(current liver function test results must be submitted)**

AND

- ❑ Treatment will be limited to a duration of 30 days

AND

- ❑ Initiation or re-initiation of therapy has been, or will be, performed in a hospital setting and serum sodium will be monitored closely **(documentation of discharge hospital record and/or chart notes MUST accompany request)**

AND

- ❑ Samsca® (tolvaptan) will not be used in the treatment of autosomal dominant polycystic kidney disease (ADPKD)

(Continued on next page; signature page is required to process request.)

(Please ensure signature page is attached to form.)

Medication being provided by Specialty Pharmacy – PropriumRx:

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Member Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**:: 11/19/2009
REVISED/UPDATED: ~~; 6/6/2011; 9/7/2011; 10/29/2014; 11/5/2014; 5/22/2015; 12/29/2015; 12/19/2016; 8/17/2017; (Reformatted) 6/21/2019;~~ **10/7/2019**