OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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 will be delayed.**

Drug Requested: Jynarque™ (tolvaptan)

DRUG INFORMATION: Authorization will 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 and diagnoses 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.

1. Does member have a diagnosis of autosomal dominant polycystic kidney disease (ADPKD)?
   ❑ Yes ❑ No

AND

2. Is member 18 years or older? ❑ Yes ❑ No

AND

3. Member does **NOT** have any of the following: ❑ Yes ❑ No
   - History of signs or symptoms of significant liver impairment or injury (not including uncomplicated polycystic liver disease);
   - Uncorrected abnormal blood sodium concentrations;
   - Hypovolemia;
   - Uncorrected urinary outflow obstruction; **OR**
   - Anuria;

AND

4. Jynarque™ is available only through a restricted distribution program under a REMS called the Jynarque™ REMS. Is the prescriber certified with the Jynarque™ REMS program? ❑ Yes ❑ No

AND

5. Is member enrolled in the Jynarque™ REMS program and educated on the risk of hepatotoxicity?
   ❑ Yes ❑ No

(Continued on next page)

AND

6. Member does **NOT** have concurrent use of strong CYP3A inhibitors. ❑ Yes ❑ No

AND

7. Baseline alanine aminotransferase (ALT), aspartate aminotransferase (AST), and bilirubin have been performed. ❑ Yes ❑ No

For Renewal, complete the following questions to receive a SIX (6) month approval.

1. Does member continue to meet the above criteria? ❑ Yes ❑ No

AND

2. Is the most recent ALT, AST, and bilirubin all within normal range (results **MUST** be within 3 months of request)? ❑ Yes ❑ No

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 #: _____

REVISED/UPDATED: 11/10/2018; **Reformatted 1/3/2020**