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. **Incomplete form will delay authorization process.**

Drug Requested: Jynarque™ (tolvaptan)

DRUG INFORMATON: Complete all information below or authorization process will be delayed.

Drug Form/Strength: _____

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

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

CLINICAL CRITERIA: To receive a **SIX (6) month approval** for this drug, **ALL** boxes **must** be checked to qualify to ensure authorization process will **NOT** be delayed.

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

AND

(continued on next page)

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.

Patient 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