Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

# Jynarque® Prior Authorization Request Form (Page 1 of 2)

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

| Member Information (required) | | | Provider Information (required) | | |
|---|---|---|---|---|---|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

## Medication Information (required)

| Medication Name: | Strength: | Dosage Form: |
|---|---|---|
| ❑ Check if requesting **brand** | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

## Clinical Information (required)

**Select the diagnosis below:**

❑ Autosomal dominant polycystic kidney disease (ADPKD)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

**Clinical Information:**

Is the provider a nephrologist and/or specialist experienced in treating ADPKD? ❑ **Yes** ❑ **No**

Select if one of the following applies to the patient:

- ❑ Aged 15–29 years: ≥3 cysts unilaterally or bilaterally
- ❑ Aged 30–59: ≥2 cysts in each kidney or ≥3 cysts unilaterally or bilaterally
- ❑ Aged ≥60 years: ≥4 cysts in each kidney

*Chart notes MUST be submitted detailing progression of disease, family history, and ultrasonographic testing confirming any of the applicable patient variables*

If family history documentation of ADPKD is not available, select the following that applies to the patient:

- ❑ Absence of other manifestations suggesting a different cystic disease
- ❑ Bilateral renal enlargement
- ❑ 10 cysts in each kidney

*Chart notes MUST be submitted detailing progression of disease, family history, and ultrasonographic testing confirming any of the applicable patient variables*

What is the patient's estimated GFR? _____ mL/min/1.73m$^2$

*Chart notes and labs MUST be submitted documenting the required criteria*

Is the decline in estimated GFR greater than 2.0 mL/min/1.73m$^2$/year? ❑ **Yes** ❑ **No**

Will the patient be titrated based on the following TITRATION RECOMMENDATION (per response and tolerability at intervals of at least 7 days)? ❑ **Yes** ❑ **No**

- Initial: 60 mg/day in divided doses (45 mg upon wakening and 15 mg approximately 8 hours later)
- 90 mg/day (60 mg upon wakening and 30 mg approximately 8 hours later), Then
- 120 mg/day (90 mg upon wakening and 30 mg approximately 8 hours later)

*Please note: If requesting strengths not in accordance to the titration recommendations, submit chart notes detailing medication history that patient has been titrated accordingly*

Are the prescriber and patient enrolled in the Jynarque REMS program? ❑ **Yes** ❑ **No**

Will the prescriber obtain ALT, AST, and bilirubin prior to initiation of therapy, at weeks 2, 4, and then monthly during the first 18 months of therapy? ❑ **Yes** ❑ **No**

*Baseline ALT, AST, and bilirubin labs must be submitted*

Will chart notes documenting the patient's ER visits and kidney-associated pain levels in the last 12 months be submitted? ❑ **Yes** ❑ **No**

*Chart notes must be submitted*

# Jynarque® Prior Authorization Request Form (Page 2 of 2)

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**Reauthorization:**

**If this is a reauthorization request, answer the following questions:**

Will ALT and AST continue to be monitored as required by the Jynarque REMS criteria? ❑ **Yes** ❑ **No**
*Current ALT and AST labs must be submitted*

Does the patient have signs or symptoms consistent with hepatic injury? ❑ **Yes** ❑ **No**

Will chart notes be submitted with ALL of the following? ❑ **Yes** ❑ **No**

- Current eGFR
- Documented decrease in patient's ER visits and kidney-associated pain levels from baseline
- Updated calculated decline from the last 12 months in estimated GFR year over year

*Chart notes must be submitted*

**Quantity limit requests:**

What is the quantity requested per MONTH? _____

Previous therapies failed and/or therapies currently used in combination with the requested medication (*List ALL medications tried or authorization process will be delayed)*:_____

_____

Is the prescribed dose higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert)? ❑ **Yes** ❑ **No**

If **Yes**, please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature).
*Please note: Chart documentation of the above is required to be submitted along with this fax*

_____

_____

**Chart notes and any lab results MUST be submitted with this request**
****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.***

**Prescriber Signature:** _____ **Date:** _____

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.