

Prior Authorization
JOHNS HOPKINS HEALTH PLANS (MEDICAID) Jynarque - Priority Partners MCO This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at 1-410-424-4607 . Please contact Johns Hopkins Health Plans at 1-888-819-1043 with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Jynarque - Priority Partners MCO.

Drug Name (select from list of drugs shown) Jynarque (tolvaptan)

Quantity	Frequency	Strength
Route of Administration	Expected Length of Therapy	

Patient Information	
Patient Name:	_____
Patient ID:	_____
Patient Group No.:	_____
Patient DOB:	_____
Patient Phone:	_____

Prescribing Physician	
Physician Name:	_____
Physician Phone:	_____
Physician Fax:	_____
Physician Address:	_____
City, State, Zip:	_____

Diagnosis: _____	ICD Code: _____
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Comments: _____

Please circle the appropriate answer for each question.	
1. Does the patient have a diagnosis of autosomal dominant polycystic kidney disease (ADPKD)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
2. Is the requested drug being prescribed to slow kidney function decline?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	

3. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.	
[If yes, skip to question 8.]	
4. Have the patient's liver function laboratory values (alanine aminotransferase [ALT], aspartate aminotransferase [AST], and bilirubin) been collected prior to therapy initiation?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
5. Is the requested drug prescribed by or under consultation with an endocrinologist, nephrologist, or transplant specialist?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
6. Is the patient 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
7. Does the prescribed dose exceed the maximum recommended dose of 120 milligrams per day?	<input type="checkbox"/> Y <input type="checkbox"/> N
[No further questions.]	
8. Has the patient's kidney function decline slowed?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
9. Is the prescriber monitoring liver function values monthly for the first 18 months of therapy, and then every 3 months?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
10. Does the prescribed dose exceed the maximum recommended dose of 120 milligrams per day?	<input type="checkbox"/> Y <input type="checkbox"/> N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date