PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS

Samsca - 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 Samsca - Priority Partners MCO.

Drug Name (select from list of drugs shown)

Samsca (tolvaptan) 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:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Does the patient have clinically significant hypervolemic or euvolemic hyponatremia (serum sodium less than 125 milliequivalents per liter [mEq/L])? Y N

NOTE: Submission of medical records is required.

[If yes, skip to question 3.]

2. Does the patient have less marked hyponatremia (serum sodium less than 135 milliequivalents per liter [mEq/L]), but Y N

	is symptomatic and is resistant to correction with fluid restriction?	
	[If no, no further questions.]	
3.	Is the patient 18 years of age or older?	Y N
	[If no, no further questions.]	
4.	Does the patient have hypovolemic hyponatremia?	Y N
	[If yes, no further questions.]	
5.	Will the requested drug be used in a patient requiring urgent intervention to raise serum sodium acutely?	Y N
	[If yes, no further questions.]	
6.	Will the requested drug be used for treatment of autosomal dominant polycystic kidney disease (ADPKD) outside of Food and Drug Administration (FDA)-approved Risk Evaluation and Mitigation Strategy (REMS)?	Y N
	[If yes, no further questions.]	
7.	Is the patient unable to sense or to respond appropriately to thirst?	Y N
	[If yes, no further questions.]	
8.	Is the patient anuric?	Y N
	[If yes, no further questions.]	
9.	Is the patient taking concomitant strong Cytochrome P450 3A (CYP 3A) inhibitors (i.e., clarithromycin, ketoconazole, itraconazole, ritonavir, indinavir, nelfinavir, saquinavir, nefazodone, and telithromycin)?	Y N
	[If yes, no further questions.]	
10.	Does the prescribed dose exceed the maximum recommended dose of 60 milligrams per day?	Y N
	[If yes, no further questions.]	
11.	Will the requested medication be used for any indications or uses that are not Food and Drug Administration (FDA)-approved or guideline-supported?	Y N
	[If yes, no further questions.]	
12.	Is the requested product brand Samsca?	Y N
	[If no, no further questions.]	
13.	Has the patient had a trial and inadequate response to generic tolvaptan?	Y N
	NOTE: Submission of medical records is required.	

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