JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete clinical assessment:**

1. Does the provider acknowledge that Jynarque requires liver function monitoring with evaluation of transaminases and bilirubin before initiating treatment, at 2 weeks and 4 weeks after initiation, then continuing monthly for the first 18 months and every 3 months thereafter?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is Jynarque being prescribed by or in consultation with a nephrologist?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have rapidly progressing autosomal dominant polycystic kidney disease (ADPKD, defined as reduced or declining renal function [i.e., glomerular filtration rate (GFR) less than or equal to 65 mL/min/1.73 m2] and high total kidney volume [i.e., greater than or equal to 750ml])?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have Stage 5 chronic kidney disease (CKD) [GFR less than 15 mL/min/1.73 m2]?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 6**
6. Is the patient receiving dialysis?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 7**

7. Is the patient currently taking Samsca (tolvaptan)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[28 November 2018]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: