Priority Partners MCO
7231 Parkway Drive, Suite 100
Hanover, MD 21076

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Prior Authorization

JOHNS HOPKINS HEALTHCARE (MEDICAID)

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 Healthcare at **1-410-424-4607**.
Please contact Johns Hopkins Healthcare 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. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y 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 no, skip to question 3.]

2. Has the patient experienced continued clinical benefit to treatment with the requested drug? Y N _____

	NOTE: Submission of medical records is required.	
	[If yes, skip to question 9.]	
	[If no, no further questions.]	
3.	Does the patient have hypovolemic hyponatremia?	Y N
	[If yes, no further questions.]	
4.	Will the requested drug be used in a patient requiring urgent intervention to raise serum sodium acutely?	Y N
	[If yes, no further questions.]	
5.	Does the patient have clinically significant hypervolemic or euvolemic hyponatremia (serum sodium less than or equal to 125 milliequivalents per liter (mEq/L) marked by hyponatremia that is symptomatic and has resisted correction with fluid restriction), including heart failure, cirrhosis, and Syndrome of Inappropriate Antidiuretic Hormone (SIADH)?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
6.	Is the patient unable to sense or to respond appropriately to thirst?	Y N
	[If yes, no further questions.]	
7.	Is the patient anuric?	Y N
	[If yes, no further questions.]	
8.	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.]	
9.	Does the prescribed dose exceed the maximum recommended dose of 60 milligrams per day?	Y 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