

# JYNARQUE

## PRIOR AUTHORIZATION REQUEST

### PRESCRIBER FAX FORM

**Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.**

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit [www.myprime.com](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermymeds.com](http://covermymeds.com) to begin using this free service.

**What is the priority level of this request?**

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

**Today's Date:** \_\_\_\_\_

**PATIENT AND INSURANCE INFORMATION**

**Date of Service (if differs from Today's Date):** \_\_\_\_\_

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

**PRESCRIBER/CLINIC INFORMATION**

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

Patient's diagnosis: <input type="checkbox"/> Autosomal dominant polycystic kidney disease (ADPKD) <input type="checkbox"/> Other (ICD code and description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

**For all requests:**

1. Is the patient currently being treated with the requested agent? .....  Yes  No
2. Does the patient have any FDA labeled contraindications to the requested agent? .....  Yes  No  
 If yes, please specify contraindication: \_\_\_\_\_
3. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., nephrologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? .....  Yes  No
4. Is the patient's age within FDA labeling for the requested indication for the requested agent? .....  Yes  No  
 If no, please provide information supporting the use of the requested agent for the patient's age for the requested indication: \_\_\_\_\_
5. Will the patient be using the requested agent in combination with another tolvaptan agent? .....  Yes  No
6. Does the requested quantity (dose) exceed the maximum FDA labeled dose for the requested indication? .....  Yes  No  
 If no, can the requested quantity (dose) be achieved with a lower quantity of a higher strength? .....  Yes  No  
 If no, please explain: \_\_\_\_\_

**For autosomal dominant polycystic kidney disease (ADPKD) requests:**

7. Does the patient have stage 5 chronic kidney disease (CKD)? .....  Yes  No
8. Is the patient on dialysis? .....  Yes  No

**Please continue to the next page.**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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**For renewal requests:**

9. Has the patient had clinical benefit with the requested agent? .....  Yes  No

**Please fax or mail this form to:**  
 Prime Therapeutics LLC  
 Clinical Review Department  
 2900 Ames Crossing Road Suite 200  
 Eagan, MN 55121

**TOLL FREE**

**Phone:** **Fax: 877.243.6930**  
**BCBSIL: 800.285.9426**  
**BCBSMT: 888.723.7443**  
**BCBSNM: 800.544.1378**  
**BCBSOK: 800.991.5643**  
**BCBSTX: 800.289.1525**

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