



2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Tolvaptan
Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Form with fields for Patient Name, Prescriber Name, Member Number, Date of Birth, Line of Business, Address, City, State ZIP, Primary Phone, Fax, Phone, Office Contact, NPI, State Lic ID, and Specialty/facility name.

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Form with fields for Drug Name, Strength, and Directions / SIG.

Please attach any pertinent medical history including labs and information for this member that may support approval. Please answer the following questions and sign.

Q1. Is the patient diagnosed with hypervolemic and euvoletic hyponatremia, including patients with heart failure and Syndrome of Inappropriate Antidiuretic Hormone (SIADH)?

Yes No

Q2. Has tolvaptan been initiated or being reinitiated in a hospital?

Yes No

Q3. Are labs (AST, ALT, bilirubin, serum sodium levels) attached and plan to be monitored?

Yes No

Q4. Is the duration of therapy limited to 30 days of treatment?

Yes No

Q5. Additional Information:



2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Tolvaptan
Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:
----------------------	-------------------------

Prescriber Signature

Date
2024 Prior Authorization Request