

Pharmacy Prior Authorization Form

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

 This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Samsca[®] (tolvaptan) Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

 Product: Samsca 15mg Samsca 30mg

Dose: _____ Start date: _____

Priority Health Precertification Requirements:

Authorization for Samsca requires:

- Diagnosis of symptomatic hyponatremia (serum Na < 30 mEq/L) unresponsive to other therapy (including, but not limited to: fluid restriction, loop diuretics, hypertonic saline (or salt tablets))
- Must be initiated or re-initiated in an inpatient setting
- Patient has been screened for drug-induced causes of hyponatremia

Diagnosis:

- Hyponatremia (serum Na < 130 mEq/L) Date of measurement: _____
- Other: _____
Please provide rationale for use: _____

Please Complete the Following Information:

- Samsca was initiated in the hospital. Date of Discharge: _____
- Patient has diagnosis of symptomatic hyponatremia: (check all that apply)
- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Malaise | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Lethargy | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Gait Disturbance |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Confusion | <input type="checkbox"/> Muscle cramps |
| <input type="checkbox"/> Seizure | <input type="checkbox"/> Other: _____ | |
- Other therapies tried:
- | | | |
|--|---|--|
| <input type="checkbox"/> Fluid restriction | <input type="checkbox"/> Loop diuretics | <input type="checkbox"/> Hypertonic saline (inpatient) |
| <input type="checkbox"/> Salt tablets | <input type="checkbox"/> Other: _____ | |
- Patient has been discontinued from any possible causes of drug-induced hyponatremia (or SIADH), including but not limited to: carbamazepine, oxcarbazepine, chlorpropamide, fluoxetine, sertraline, vincristine, vinblastine, cisplatin, cyclophosphamide, thiothixene, thioridazine, haloperidol, amitriptyline, MAO inhibitors, methotrexate, NSAIDs, interferon alpha and gamma, amiodarone, ciprofloxacin, and opiates.

Authorization and limitation: Maximum 60mg/day

FOR MEDICARE ONLY

If none of the above precertification criteria is applicable to this member, please check off which, if any, of the following apply:

1. All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
2. The number of doses available under a dose restriction for the prescription drug:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
3. The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
 - c. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
4. None of the above apply

****If you selected 1, 2, or 3 above, supporting evidence/documentation is required for review. If no supporting evidence/documentation is provided, this request will not be approved.**

***** All fields must be complete and legible for Prior Authorization Review***
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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**