Pharmacy Prior Authorization Form

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

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)**
☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Samsca® (tolvaptan)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Samsca 15 mg tablet
☐ Samsca 30 mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Diagnosis of symptomatic hyponatremia (serum sodium less than 130 mEq/L) unresponsive to other therapy (including, but not limited to, fluid restriction, loop diuretics, hypertonic saline [or salt tablets])
2. Must be initiated or re-initiated in an inpatient setting
3. Patient must be screened for drug-induced causes of hyponatremia

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 09/2018
Last reviewed 09/2018

Priority Health Precertification Documentation

A. What is the patient's diagnosis?

☐ Hyponatremia (serum sodium less than 130 mEq/L)
Date of lab: _____

☐ *Other – the patient's condition is:* _____
Rationale for use: _____

B. Is the patient's hyponatremia symptomatic?

☐ No. **Rationale for use:** _____

☐ Yes. **Please check all that apply:**

☐ nausea ☐ malaise ☐ headache ☐ lethargy ☐ muscle cramps
☐ seizure ☐ dizziness ☐ gait disturbance ☐ forgetfulness ☐ confusion
☐ Other symptom(s): _____

C. ☐ Samsca was initiated in the hospital. The discharge date is/is expected to be: _____

D. What other therapies have been tried?

☐ fluid restriction ☐ loop diuretics ☐ salt tablets ☐ hypertonic saline (inpatient setting)
☐ Other: _____

E. ☐ 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
- ciplatin
- cyclophosphamide
- thiothixene
- thioridazine
- haloperidol
- amitriptyline
- MAO inhibitors (e.g. phenelzine, tranylcypromine)
- Methotrexate
- NSAIDs
- interferon alpha and gamma
- amiodarone
- ciprofloxacin
- opiates

Additional information

Note: When criteria are met, the maximum dose authorized is 60 mg per day. Coverage duration is limited to 30 days.

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