Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

CVS caremark™ {{PANUMCODE}}

Jynarque

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the diagnosis?
   ❑ Autosomal dominant polycystic kidney disease (ADPKD) ❑ Other _____
2. What is the ICD-10 code? _____
3. What is the patient's estimated glomerular filtration rate (eGFR)? _____ mL/min/1.73m^2
4. Is the request for a continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #6*
5. Has the patient experienced a beneficial response to the requested drug therapy (e.g., slowed kidney function decline, decreased kidney pain)? ❑ Yes ❑ No *No further questions*
6. Does the patient have a first degree relative with autosomal dominant polycystic kidney disease (ADPKD)?
   ❑ Yes ❑ No *If No, skip to #8*
7. Is the diagnosis of autosomal dominant polycystic kidney disease (ADPKD) confirmed by the presence of greater than any of the following using any radiologic method? ***ACTION REQUIRED: Please attach imaging related to, or chart notes used for diagnosis.***
   ❑ Greater than or equal to 3 cysts (unilateral or bilateral) ❑ Greater than or equal to 2 cysts per kidney
   ❑ Greater than or equal to 4 cysts per kidney ❑ None of the above
8. Does the patient have a mutation in the PKD1 or PKD2 gene as confirmed by a positive genetic test?
   ACTION REQUIRED: If Yes, please attach laboratory report confirming presence of genetic mutation.
   ❑ Yes ❑ No
9. Does the patient have or is at risk for rapidly progressing disease? ❑ Yes ❑ No
10. Does the patient have height-adjusted total kidney volume compatible with Mayo class 1C, 1D, or 1E disease?
    ACTION REQUIRED: If Yes, please attach imaging related to, or chart notes used for confirmation of rapidly progressing disease. ❑ Yes ❑ No/Unknown

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit CVS Caremark Prior Authorization Fax: 1-866-249-6155