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}}

**ICD-10 Code: _____**
**Prescribed Drug and Dosage Form: _____**
**Is a loading dose required:** ❑ Yes ❑ No
**Prescribed Loading dose and duration: _____**

**Maintenance Dose and Frequency: _____**

1. What is the diagnosis?
   ❑ Autosomal dominant polycystic kidney disease (ADPKD)
   ❑ Other: _____
2. Is the request for a continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #5*
3. Has the patient experienced a beneficial response to the requested drug (e.g., slowed kidney function decline, decreased kidney pain)? ❑ Yes ❑ No
4. What is the patient's estimated glomerular filtration rate (eGFR)? _____ mL/min/1.73$^2$ *No further questions.*
5. If the patient is 18 years or age or older, *continue to #6*.
   If the patient is less than 18 years of age, *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 #11*
7. See below for skip logic based on patient's age.
   ❑ 18 to less than 40 years old, *continue to #8*
   ❑ 40 to less than 60 years old, *skip to #9*
   ❑ 60 years old or older, *skip to #10*
8. Is the diagnosis of autosomal dominant polycystic kidney disease (ADPKD) confirmed by the presence of greater than or equal to 3 cysts (unilateral or bilateral) using any radiologic method? ***ACTION REQUIRED: If Yes, please attach imaging related to, or chart notes used for diagnosis.*** ❑ Yes ❑ No *Skip to #12*

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

9. Is the diagnosis of autosomal dominant polycystic kidney disease (ADPKD) confirmed by the presence of greater than or equal to 2 cysts per kidney using any radiologic method? ***ACTION REQUIRED: If Yes, please attach imaging related to, or chart notes used for diagnosis.*** ❑ Yes ❑ No *Skip to #12*

10. Is the diagnosis of autosomal dominant polycystic kidney disease (ADPKD) confirmed by the presence of greater than or equal to 4 cysts per kidney using any radiologic method? ***ACTION REQUIRED: If Yes, please attach imaging related to, or chart notes used for diagnosis.*** ❑ Yes ❑ No *Skip to #12*

11. 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

12. Does the patient have or is at risk for rapidly progressing disease? ❑ Yes ❑ No

13. 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

14. What is the patient's estimated glomerular filtration rate (eGFR)? _____ mL/min/$1.73^2$

***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)**

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