FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Jynarque® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Autosomal dominant polycystic kidney disease (ADPKD)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is the patient at risk of rapidly progressing kidney disease? ❑ **Yes** ❑ **No**

Are baseline serum transaminases and bilirubin obtained prior to initiation of therapy? ❑ **Yes** ❑ **No**

Is Jynarque prescribed by a nephrologist or kidney transplant specialist? ❑ **Yes** ❑ **No**

Reauthorization:

Has the decline in kidney function slowed? ❑ **Yes** ❑ **No**

Has the patient's kidney pain improved? ❑ **Yes** ❑ **No**

Does the patient have serum transaminases less than 3 times the upper limit of normal? ❑ **Yes** ❑ **No**

Does the patient have bilirubin less than 2 times the upper limit of normal? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.