



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

### Jynarque® Prior Authorization Request Form

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#### 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:
<input type="checkbox"/> Check if generic substitution is acceptable		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

#### 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?

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

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