CHORUS COMMUNITY HEALTH PLANS

Prior Authorization Form: **Jynarque**

If this is an urgent request, please call Chorus Community Health Plans Pharmacy Services.
Otherwise, please return completed form – Phone: 844-201-4677 or Fax: 844-201-4675

PLEASE TYPE OR PRINT NEATLY
Incomplete responses may delay this request.

Office contact:		Provider specialty:	
Provider first name:		Provider last name:	
Provider phone #:	Provider fax #:	Provider NPI #:	
Patient name:	CCHP Member ID #:	Patient DOB:	Patient age:
Drug requested: Brand ◯ Generic ◯	Strength:	Frequency:	Quantity dispensed (including units):

Generic equivalent drugs will be substituted for brand name drugs unless you specifically indicate otherwise.

◯ New medication ◯ Ongoing medication	If ongoing, please provide start date:	If ongoing, did the member show improvement while on therapy?	◯ Yes ◯ No

Diagnosis:

Place of administration: Physician's Office ◯ Hospital/Facility ◯ Patient Home ◯ Other ◯

Please provide hospital/facility information: Name: _____ Phone: Address:_____ _____	Please indicate how medication will be billed: ◯ Billed directly by the provider via JCODE JCODE: _____ ◯ Billed by a pharmacy and delivered to the provider ◯ Billed by a pharmacy and delivered to the patient

Is the prescriber enrolled in the Jynarque REMS program? Yes ◯ No ◯

Does the patient have a confirmed diagnosis of ADPKD? Yes ◯ No ◯

How many cysts does the patient have in each kidney? _____

Documentation enclosed? Yes ◯ No ◯

If family history documentation of ADPKD is unavailable, have other cystic kidney diseases been ruled out? Yes ◯ No ◯

Does the patient have rapidly progressing disease? Yes ◯ No ◯

What is the patient's most recent estimated GFR (eGFR)? Result: _____ mL/min/1.73m^2 Date: _____

Does the patient have hypertension? Yes ◯ No ◯

If yes, is the patient receiving treatment? Please list: _____

Has the patient had a baseline ALT, AST and bilirubin level checked prior to starting therapy? Yes ◯ No ◯

Does the patient have a history of significant liver impairment or injury? Yes ◯ No ◯

Is this request for a reauthorization? Yes ◯ No ◯

If yes, please include all of the following documentation:
- Documentation showing disease has stabilized or improved while on therapy
- Documentation that the patient's ALT and AST levels are monitored consistently

Most recent estimated GFR (eGFR) Result: _____ mL/min/1.73m^2 Date: _____

Please provide any additional information in the space below.