

Prescriber Criteria Form

Jynarque 2026 PA Fax 2573-A v1 010126.docx

Jynarque (tolvaptan)

Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.

Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Jynarque (tolvaptan).

Drug Name:
Jynarque (tolvaptan)

Patient Name:

Patient ID:

Patient DOB:

Patient Phone:

Prescriber Name:

Prescriber Address:

City:

State:

Zip:

Prescriber Phone:

Prescriber Fax:

Diagnosis:

ICD Code(s):

Please circle the appropriate answer for each question.

1	Is the requested medication being prescribed for a patient at risk of rapidly progressing autosomal dominant polycystic kidney disease (ADPKD)?	Yes	No
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Comments: _____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ Date: _____