

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

SAMSCA (tolvaptan)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES AND THIS COMPLETED
FORM TO 855-828-4992 note the new fax number**

CRITERIA:

- Documentation that therapy was initiated in the hospital.
- Documentation that Samsca is required for hypervolemic or euvolemic hyponatremia associated with heart failure, cirrhosis, or SIADH
- Documentation that serum sodium $\leq 125\text{mEq/L}$
- Documentation that hyponatremia is symptomatic if serum sodium $> 125\text{mEq/L}$
AND documented failure of other treatment strategies including but not limited to:
 - documented failure of fluid restriction
 - documented failure of salt administration (for euvolemic hyponatremia only)
 - documented failure of demeclocycline (for SIADH only)
- Evidence is required that the underlying disease state causing the hyponatremia is being adequately treated.
- Dose limited to 60mg daily.

AUTHORIZATION:

Initial authorization will be granted for 60 days.

RE-AUTHORIZATION:

Subsequent authorizations will only be granted by petition to the DUR Board.

07/14/2011

<http://health.utah.gov/medicaid/pharmacy>