

## Samsca (tolvaptan)

<b>Member and Medication Information</b>	
* indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	<input type="checkbox"/> Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
<b>Provider Information</b>	
* indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at <b>855-828-4992</b> , to prevent processing delays.	

**Samsca Criteria for Approval (ALL criteria must be met):**

- Treatment of clinically significant hypervolemic and euvolemic hyponatremia
- Dose limited to 60mg daily and to 30 days duration.
- Documentation that therapy was initiated in the hospital.
- Documentation that serum sodium  $\leq$  125mEq/L. **OR**
- Documentation that hyponatremia is symptomatic if serum sodium  $>$  125mEq/L **AND** documented failure of other treatment strategies including but not limited to:
  - o Fluid restriction
  - o Salt administration (for euvolemic hyponatremia only)
- Evidence is required that the underlying disease state causing the hyponatremia is being adequately treated.

**Re-authorization Criteria:**

Updated letter with medical justification or updated chart notes demonstrating positive clinical response.

**Samsca only: Authorization** up to one (1) month

**PROVIDER CERTIFICATION**

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

\_\_\_\_\_  
 Prescriber's Signature

\_\_\_\_\_  
 Date