

Jynarque (tolvaptan)

Coverage Criteria:

1. Prescribed by a nephrologist; and,
2. Patient is an adult diagnosed with autosomal dominant polycystic kidney disease (ADPKD) confirmed by at least one of the following; and,
 - a. Ultrasonography; or,
 - b. MRI; or,
 - c. CT scan; or,
 - d. Genetic testing; and,
3. Estimated GFR is ≥ 60 mL/ min at treatment baseline (within previous 3 months); and
4. Patient is at risk of rapid progression, as defined by at least one of the following; and,
 - a. Total kidney volume ≥ 750 cc; or,
 - b. Kidney length >16.5 cm in patients less than 50 years of age; or,
 - c. Classified as Mayo classes 1C, 1D, or 1E using the Mayo ADPKD Classification assessment; or,
 - d. PROPKD score >6 ; and,
5. Prescribed within the FDA approved regimen.

Coverage Duration:

Authorizations will be provided for 12 months.

Renewal Criteria:

1. Patients who continue to meet the criteria above; and
2. Approval requires medical documentation demonstrating adherence to the medication; and
3. Patient has been seen by the provider within the previous 12 months; and
4. Patient continues to receive a positive effect from the medication such as absence of renal pain or provider attestation that disease progression is less than expected.