BCRenal
Provincial Health Services Authority

Tolvaptan Prescription
For Polycystic Kidney Disease

PATIENT INFORMATION LABEL

Name: _____

Address: _____

Phone: _____

Date of Birth (MM/DD/YYYY): _____

PHN: _____

DRUG AND FOOD ALLERGIES

✹ Mandatory ☐ Optional: Prescriber check (✓) to initiate, cross out and initial any orders not indicated.

To obtain TOLVAPTAN for your patient:

✹ Ensure the patient is registered in PROMIS with diagnosis of ADPKD.
✹ Fax this prescription to Macdonald's Pharmacy at 1-855-569-0660.
✹ If this is a new prescription, also fax a completed Patient Provider Agreement Form (PPAF) to Macdonald's Pharmacy and ensure that baseline blood tests are completed and reviewed prior to initiation.

Please ensure an application has been approved by BC Renal before faxing this prescription to Macdonald's. If there is no approved application for the patient, the prescription cannot processed.

This is a:

☐ New prescription ☐ Change to existing prescription ☐ Annual prescription renewal

TOLVAPTAN split dose regimen:

☐ **TOLVAPTAN** 45 mg PO every morning and 15 mg po 8 hours later (usual starting dose)
☐ **TOLVAPTAN** 60 mg PO every morning and 30 mg po 8 hours later
☐ **TOLVAPTAN** 90 mg PO every morning and 30 mg po 8 hours later

There are also lower doses available listed below. These are not intended as starting doses, but rather are for patients who experience excessive/intolerable aquaretic symptoms on the conventional doses, or are concurrently taking other medications that affect tolvaptan pharmacokinetics.

☐ **TOLVAPTAN** 15 mg PO every morning and 15 mg po 8 hours later
☐ **TOLVAPTAN** 30 mg PO every morning and 15 mg po 8 hours later

Quantity:

☐ 12 month supply dispensed at 4 week intervals after reviewing blood work (default option)
☐ 12 month supply dispensed at 8 week intervals after reviewing blood work
(only choose this option if the patient has been on treatment for over 18 months)
☐ Other: _____

Note: Tolvaptan cannot be dispensed without evidence of up-to-date monitoring of hepatic enzymes.

DATE (DD/MM/YYYY)	PRESCRIBER NAME (PRINTED)	PRESCRIBER SIGNATURE	COLLEGE ID	CONTACT NUMBER