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Nocturnal Polyuria Treatments Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004.
Provider Help Desk: 1-800-454-3730

1. Patient information	**2. Physician information**
Patient name:_____	Prescribing physician:_____
Patient ID #: _____	Physician address: _____
Patient DOB:_____	Physician phone #: _____
Date of Rx: _____	Physician fax #:_____
Patient phone #:_____	Physician specialty:_____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
☐ Nocdurna ☐ Noctiva	_____	_____	Specify: _____

7. Diagnosis:_____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization is required for nocturnal polyuria agents. Payment will be considered for patients when the following criteria are met:

1. Patient meets the FDA approved age: and
2. Patient has a diagnosis of nocturnal polyuria as confirmed by a 24-hour collection which notes the presence of greater than 33% of 24-hour urine production occurring at night; and
3. Patient wakens at least 2 times at night to void; and
4. Patient has attempted fluid restriction in the evenings without improvement in nocturnal polyuria; and
5. Patient is not taking a diuretic in the evening; and
6. Patient does not have any of the following contraindications; and
    a. Current or previous history of hyponatremia; and
    b. Primary nocturnal enuresis; and
    c. Polydipsia; and
    d. Concomitant use with loop diuretics, systemic or inhaled glucocorticoids; and
    e. Known or suspected syndrome of inappropriate antidiuretic hormone (SIADH) secretion; and
    f. Estimated glomerular filtration rate > 50 mL/min/1.73 m^2; and
    g. Illnesses that can cause fluid or electrolyte imbalance; and
    h. New York Heart Association (NYHA) Class II-IV congestive heart failure; and
    i. Uncontrolled hypertension.

Initial requests will be considered for 3 months. Requests for continuation of therapy will require the following:

1. Patient continues to meet above criteria; and
2. Patient has experienced a decrease in nocturnal voiding; and
3. There is no evidence of toxicity (e.g., hyponatremia, fluid retention, or electrolyte imbalances).

Was diagnosis confirmed by a 24-hour collection which notes 33% of 24-hour urine production occurring at night?

□ Yes (attach results)

□ No

□ **Initial Requests:**

□ Yes □ No Does patient waken at least 2 times a night to void?

□ Yes □ No Has patent attempted fluid restriction in the evenings without improvement in nocturnal polyuria?

□ Yes □ No Is patient taking a diuretic in the evening?

□ Yes □ No Does patient have any of the following contraindications?

- Current or previous history of hyponatremia
- Primary nocturnal enuresis
- Polydipsia
- Concomitant use with loop diuretics, systemic or inhaled glucocorticoids
- Known or suspected syndrome of inappropriate antidiuretic hormone (SIADH) secretion
- Estimated glomerular filtration rate < 50 mL/min/1.73 m2
- Illnesses that can cause fluid or electrolyte imbalance
- New York Heart Association (NYHA) Class ll-lV congestive heart failure
- Uncontrolled hypertension

□ **Renewal Requests (all criteria above, plus the following):**

□ Yes □ No Has patient experienced a decrease in nocturnal voiding?

□ Yes □ No Is there evidence of toxicity (e.g., hyponatremia, fluid retention, or electrolyte imbalance)?

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.