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Nonparenteral Vasopressin Derivatives of Posterior Pituitary Hormone Products 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 or 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**
_____	_____	_____	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 nonparenteral vasopressin derivatives of posterior pituitary hormone products. No PA is required for members 6 years of age or older when dosed within established quantity limits for desmopressin acetate tablets. Payment for preferred nonparenteral vasopressin derivatives of posterior pituitary hormone products will be authorized for the following diagnoses: 1. Diabetes Insipidus, 2. Hemophilia A and 3. Von Willebrand's disease.

Requests for desmopressin nasal spray for the treatment of nocturnal enuresis will not be considered. Payment for nonpreferred nonparenteral vasopressin derivatives will be authorized only for cases in which there is documentation of trial(s) and therapy failure with the preferred agent(s). Please refer to the *Selected Brand-Name Drugs Prior Authorization Form* if requesting a nonpreferred brand-name product.

Preferred
- ☐ Desmopressin Nasal Solution
- ☐ Desmopressin Nasal Spray
- ☐ Desmopressin Tablets
- ☐ Stimate Nasal Spray

Nonpreferred
- ☐ DDAVP Acetate Nasal Solution
- ☐ DDAVP Acetate Nasal Spray
- ☐ DDAVP Tablets

Diagnosis:

☐ Diabetes insipidus
☐ Hemophilia A
☐ Von Willebrand's disease
☐ Other (please specify)_____
☐ Nocturnal enuresis*

*If nocturnal enuresis, is patient 6 years old or older? ☐ Yes ☐ No
Please specify exact date range of last drug-free interval: From: _____To:_____

Previous therapy (include drug name(s), strength and exact date ranges): _____
_____
_____

Reason for use of nonpreferred drug requiring prior approval:_____
_____

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.