Amerigroup

Medicaid

# *Desmopressin*
# *Prior Authorization of Benefits Form*

**Contains confidential patient information**
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at **844-474-3341.**

| **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** |
|---|---|---|---|
| □ DDAVP | □ 0.1 mg tablet<br>□ 0.2 mg tablet<br>□ 4 mcg/mL ampul<br>□ 4 mcg/mL vial | ______________________ | Specify: ______________________ |
| □ desmopressin acetate | □ 0.1 mg tablet<br>□ 0.2 mg tablet<br>□ 4 mcg/mL vial | | |

**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.)

**All requests**
□ Yes □ No Patient has a diagnosis of moderate to severe renal impairment in the last 365 days

**Requests for oral DDAVP (desmopressin acetate):**
□ Yes □ No Patient has a diagnosis of primary nocturnal enuresis or diabetes insipidus in the last 730 days

**Requests for injectable DDAVP (desmopressin acetate):**
□ Yes □ No Patient has a diagnosis of diabetes insipidus, hemophilia, or Von Willebrand's disease in the last 730 days
□ Yes □ No Patient has a history of anti-hemophilic factor agents in the last 730 days



Amerigroup members in the Medicaid Rural Service Area and the STAR Kids program are served by Amerigroup Insurance Company; all other Amerigroup members in Texas are served by Amerigroup Texas, Inc.

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For the *Medicaid Preferred Drug List*, please refer to the Medicaid Vendor Drug Program website at https://www.txvendordrug.com/formulary/formulary-search

**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.

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