FAX Completed Form To
1.833.404.2392
Pharmacy Help Desk
1.800.460.8988
Prescriber Help Desk
1.833.587.2012

Request for Prior Authorization
NON-PARENTERAL VASOPRESSIN DERIVATIVES OF POSTERIOR PITUITARY HORMONE PRODUCTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for non-parenteral 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 non-parenteral 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 non-preferred non-parenteral 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 non-preferred brand-name product.

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

Non-Preferred
- ☐ DDAVP Acetate Nasal Solution
- ☐ DDAVP Acetate Nasal Spray
- ☐ DDAVP Tablets

Strength _____ **Dosage Instructions** _____ **Quantity** _____ **Days Supply** _____

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 Non-Preferred drug requiring prior approval:_____

_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*