





## **FAX Completed Form To** 1.833.404.2392

#### Prescriber Help Desk 1.833.587.2012

Online covermymeds.com/main/ prior-authorization-forms/

# Request for Prior Authorization Nocturnal Polyuria Treatments (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 nocturnal polyuria agents. Payment will be considered for patients when the following criteria are met:				
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				
<ul> <li>6) Patient does not have any of the following contraindications; and</li> <li>a) Current or previous history of hyponatremia; and</li> <li>b) Primary nocturnal enuresis; and</li> </ul>				
<ul> <li>c) Polydipsia; and</li> <li>d) Concomitant use with loop diuretics, systemic or inhaled glucocorticoids; and</li> <li>e) Known or suspected syndrome of inappropriate antidiuretic hormone (SIADH) secretion; and</li> <li>f) Estimated glomerular filtration rate &lt; 50 mL/min/1.73 m²; and</li> <li>g) Illnesses that can cause fluid or electrolyte imbalance; and</li> <li>h) New York Heart Association (NYHA) Class II-IV congestive heart failure; and</li> <li>i) Uncontrolled hypertension.</li> </ul>				
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 not evidence of toxicity (e.g., hyponatremia, fluid retention, or electrolyte imbalances).				
Non-Preferred				
☐ Nocdurna ☐ No	octiva			
Strength	Dosage Instructions	Quantity	Days Supply	

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Diagnosis:





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#### **Request for Prior Authorization Nocturnal Polyuria Treatments** (PLEASE PRINT - ACCURACY IS IMPORTANT)

Diagnosis			
Was diagnosis confirmed by a 24-hour collection which notes 33% of 24 at night? Yes (attach results) No	I-hour urine production occurring		
☐ Initial Requests:			
Does patient waken at least 2 times at night to void?	☐ No		
Has patient attempted fluid restriction in the evenings without improv ☐ Yes ☐ No	ement in nocturnal polyuria?		
Is patient taking a diuretic in the evening?	☐ No		
<ul> <li>Does patient have any of the following contraindications?  Yes  No</li> <li>Current or previous history of hyponatremia</li> <li>Primary nocturnal enuresis</li> <li>Polydipsia</li> <li>Concomitant use with loop diuretics, systemic or inhaled glucocorticoids</li> <li>Known or suspected syndrome of inappropriate antidiuretic hormone (SIADH) secretion</li> <li>Estimated glomerular filtration rate &lt; 50 mL/min/1.73 m²</li> <li>Illnesses that can cause fluid or electrolyte imbalance</li> <li>New York Heart Association (NYHA) Class II-IV congestive heart failure</li> <li>Uncontrolled hypertension</li> </ul>			
Renewal Requests (all criteria above, plus the following):			
Has patient experienced a decrease in nocturnal voiding?   Yes	☐ No		
Is there evidence of toxicity (e.g., hyponatremia, fluid retention, or el ☐ Yes ☐ No	ectrolyte imbalance)?		
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.

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