





## **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 NON-PARENTERAL VASOPRESSIN DERIVATIVES OF POSTERIOR PITUITARY HORMONE PRODUCTS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

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IA Medicaid Member ID #	Patient name			DOB					
Patient address									
Provider NPI	Prescriber name			Phone					
Prescriber address									
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									
					1				
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  Non-Preferred									
Desmopressin Nasal Solution DDAVP Acetate Nasal Solution									
<ul><li>☐ Desmopressin Nasal Spray</li><li>☐ DDAVP Acetate Nasal Spray</li><li>☐ DDAVP Tablets</li></ul>				пау					
Stimate Nasal Spray	l	_ DDAVE Table	515						
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Strength ————	Dosage Instructions	Quantity ————	Days Sup	оріу —					
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 pre	escriber listed above.)		Date of sub	mission					

**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.