

# US Family Health Plan

## Prior Authorization Request Form for desmopressin acetate (Nocdurna)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed to 617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:

**Attn: Pharmacy, 77 Warren St, Brighton, MA 02135**

QUESTIONS? **Call 1-877-880-7007**

***Prior authorization for initial therapy will approve for 4 months and renewal therapy will approve for 6 months. For renewal of therapy an initial prior authorization approval is required.***

**Step 1** Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID #: _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

**Step 2** Please complete the clinical assessment:

<b>1. Has the patient received this medication under the TRICARE benefit in the last 6 months? Please choose "No" if the patient did not previously have a TRICARE approved PA for Nocdurna. Patient/Provider must answer questions about medical conditions and medications each time (Questions 18, 19, and 20)</b>	<input type="checkbox"/> Yes (subject to verification) Proceed to question <b>17</b>	<input type="checkbox"/> No Proceed to question <b>2</b>
<b>2. Is Nocdurna being prescribed by an urologist, a geriatrician, an endocrinologist, or a nephrologist?</b>	<input type="checkbox"/> Yes Proceed to question <b>3</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>3. Has nocturnal polyuria been confirmed with a 24-hour urine collection?</b>	<input type="checkbox"/> Yes Proceed to question <b>4</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>4. Has the patient had 2 or more nocturnal voids per night for at least 6 months?</b>	<input type="checkbox"/> Yes Proceed to question <b>5</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>5. Is the patient GREATER than or EQUAL to 18 years of age?</b>	<input type="checkbox"/> Yes Proceed to question <b>6</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>6. Is the patient GREATER than or EQUAL to 65 years of age?</b>	<input type="checkbox"/> Yes Proceed to question <b>7</b>	<input type="checkbox"/> No Proceed to question <b>8</b>
<b>7. Provider acknowledges that patients over 65 years old are at greater risk of hyponatremia and has advised the patient about this significant safety concern?</b>	<input type="checkbox"/> Yes Proceed to question <b>8</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>8. Is the provider aware that Nocdurna has a black box warning for risk of hyponatremia?</b>	<input type="checkbox"/> Yes Proceed to question <b>9</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved

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<p>9. Has the patient tried non-pharmacologic techniques or lifestyle interventions to manage the nocturia (e.g., nighttime fluid restriction, avoidance of caffeine and alcohol, earlier timing of medications, leg elevation and/or use of compression stockings)?</p>	<p><input type="checkbox"/> Yes Proceed to question <b>10</b></p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>10. Has the patient tried oral desmopressin acetate tablets (DDAVP tablets, generics)?</p>	<p><input type="checkbox"/> Yes Proceed to question <b>11</b></p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>11. Is the patient male or female?</p>	<p><input type="checkbox"/> Male Proceed to question <b>12</b></p>	<p><input type="checkbox"/> Female Proceed to question <b>13</b></p>
<p>12. Is the dose being prescribed 55.3 mcg?</p>	<p><input type="checkbox"/> Yes Proceed to question <b>14</b></p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>13. Is the dose being prescribed 27.7 mcg?</p>	<p><input type="checkbox"/> Yes Proceed to question <b>14</b></p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>14. Provider must supply most recent serum sodium and date.  Sodium _____ mEq/mL Date _____</p>	<p><input type="checkbox"/> Yes Proceed to question <b>15</b></p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved  Not approved if sodium level is not provided</p>
<p>15. Does the patient have a normal sodium level (135-145 meq/L) prior to initiation of therapy?</p>	<p><input type="checkbox"/> Yes Proceed to question <b>16</b></p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>16. Will the patient's sodium level be rechecked after one week of therapy, and another sodium level is rechecked after 1 month of therapy?</p>	<p><input type="checkbox"/> Yes Proceed to question <b>18</b></p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>17. Has the patient shown a reduction in nocturia episodes?</p>	<p><input type="checkbox"/> Yes Proceed to question <b>18</b></p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>18. Does the patient have any of the following conditions: renal impairment (eGFR less than 50 mL/min), hyponatremia or history of hyponatremia, polydipsia, nocturnal enuresis, SIADH, congestive heart failure, uncontrolled hypertension or uncontrolled diabetes mellitus, Interstitial cystitis, Chronic prostatitis/chronic pelvic pain syndrome, Suspicion of bladder outlet obstruction (BOO) or urine flow, surgical treatment, OR including transurethral resection, for BOO or benign prostatic hyperplasia within the past 6 months?</p>	<p><input type="checkbox"/> Yes <b>STOP</b> Coverage not approved</p>	<p><input type="checkbox"/> No Proceed to question <b>19</b></p>

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<p>19. Does the patient have any of the following conditions: urinary retention or a post-void residual volume in excess of 250 mL as confirmed by bladder ultrasound performed after suspicion of urinary retention, current or a history of urologic malignancies (eg urothelium, prostate, or kidney cancer), genitourinary tract pathology (eg infection or stone in the bladder and urethra causing symptoms), neurogenic detrusor activity (detrusor overactivity), suspicion or evidence of cardiac failure, history of obstructive sleep apnea, hepatic and/or biliary diseases, previous desmopressin treatment for nocturia, treatment with another investigational product within 3 months prior to initiating therapy, known alcohol or substance abuse OR work or lifestyle that may have interfered with regular nighttime sleep?</p>	<p style="text-align: center;"><input type="checkbox"/> Yes <b>STOP</b> Coverage not approved</p>	<p style="text-align: center;"><input type="checkbox"/> No Proceed to question 20</p>
<p>20. Is the patient currently taking any of the following medications: loop diuretics, thiazide diuretics, systemic or inhaled corticosteroids, lithium, alpha1-adrenoceptor antagonists, 5-alpha reductase inhibitors (5-ARIs), anticholinergics, antispasmodics, sedative/hypnotic agents, NSAIDs, selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), antidepressants, anti-epileptics, opioids, or sodium glucose co-transporter 2 inhibitors (SGLT2s)?</p>	<p style="text-align: center;"><input type="checkbox"/> Yes <b>STOP</b> Coverage not approved</p>	<p style="text-align: center;"><input type="checkbox"/> No Sign and date below</p>

**Step 3** I certify the above is true to the best of my knowledge. Please sign and date:

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date