Prior Authorization Request Form for
desmopressin acetate (Nocdurna)

JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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:

Question	Yes	No
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)*	☐ Yes (subject to verification) Proceed to question **17**	☐ No Proceed to question **2**
2. **Is Nocdurna being prescribed by an urologist, a geriatrician, an endocrinologist, or a nephrologist?**	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. **Has nocturnal polyuria been confirmed with a 24-hour urine collection?**	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. **Has the patient had 2 or more nocturnal voids per night for at least 6 months?**	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. **Is the patient GREATER than or EQUAL to 18 years of age?**	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved
6. **Is the patient GREATER than or EQUAL to 65 years of age?**	☐ Yes Proceed to question **7**	☐ No Proceed to question **8**
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?**	☐ Yes Proceed to question **8**	☐ No **STOP** Coverage not approved
8. **Is the provider aware that Nocdurna has a black box warning for risk of hyponatremia?**	☐ Yes Proceed to question **9**	☐ No **STOP** Coverage not approved

Prior Authorization Request Form for
desmopressin acetate (Nocdurna)

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)?	☐ Yes Proceed to question **10**	☐ No **STOP** Coverage not approved
10. Has the patient tried oral desmopressin acetate tablets (DDAVP tablets, generics)?	☐ Yes Proceed to question **11**	☐ No **STOP** Coverage not approved
11. Is the patient male or female?	☐ Male Proceed to question **12**	☐ Female Proceed to question **13**
12. Is the dose being prescribed 55.3 mcg?	☐ Yes Proceed to question **14**	☐ No **STOP** Coverage not approved
13. Is the dose being prescribed 27.7 mcg?	☐ Yes Proceed to question **14**	☐ No **STOP** Coverage not approved
14. Provider must supply most recent serum sodium and date. **Sodium ____________mEq/mL Date___________**	☐ Yes Proceed to question **15**	☐ No **STOP** Coverage not approved Not approved if sodium level is not provided
15. Does the patient have a normal sodium level (135-145 meq/L) prior to initiation of therapy?	☐ Yes Proceed to question **16**	☐ No **STOP** Coverage not approved
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?	☐ Yes Proceed to question **18**	☐ No **STOP** Coverage not approved
17. Has the patient shown a reduction in nocturia episodes?	☐ Yes Proceed to question **18**	☐ No **STOP** Coverage not approved
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?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **19**

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?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question 20
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)?	☐ Yes **STOP** Coverage not approved	☐ No **Sign and date below**

Step 3

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

Prescriber Signature ____________________ Date __________

[25 July 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: