Prior Authorization Request Form for
desmopressin nasal spray (Noctiva)

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

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

USFHP Pharmacy Prior Authorization Form

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:**

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 Noctiva. Patient/Provider must answer questions about medical conditions and medications each time (Questions 17, 18, and 19)*	☐ Yes Proceed to question **16**	☐ No Proceed to question **2**
2. Is Noctiva 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 50 years of age? (Only the low dose is allowed for patients greater than 65 years old)	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved
6. Is the patient GREATER than or EQUAL to 65 years of age? (Only the low dose is allowed for patients greater than 65 years old)	☐ 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 Noctiva has a black box warning for risk of hyponatremia?	☐ Yes Proceed to question **9**	☐ No **STOP** Coverage not approved

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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. Provider must supply most recent serum sodium and date. **Sodium _____mEq/mL Date_____** Not approved if sodium level is not provided	☐ Yes Proceed to question **12**	☐ No **STOP** Coverage not approved Not approved if sodium level is not provided
12. Does the patient have a normal sodium level (135-145 meq/L) prior to initiation of therapy?	☐ Yes Proceed to question **13**	☐ No **STOP** Coverage not approved
13. 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 **14**	☐ No **STOP** Coverage not approved
14. Does the patient have acute or chronic rhinitis?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **15**
15. Does the patient have atrophy of nasal mucosa?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **17**
16. Has the patient shown a reduction in nocturia episodes?	☐ Yes Proceed to question **17**	☐ No **STOP** Coverage not approved
17. 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** • **uncontrolled diabetes mellitus** • **Interstitial cystitis** • **Chronic prostatitis/chronic pelvic pain syndrome** • **Suspicion of bladder outlet obstruction (BOO) or urine flow,** • **surgical treatment, including transurethral resection, for BOO or benign prostatic hyperplasia within the past 6 months**	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **18**

18. 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 **19**
19. 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

[12 September 2019]

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