



Request for Prior Authorization
NON-PARENTERAL VASOPRESSIN DERIVATIVES OF
POSTERIOR PITUITARY HORMONE PRODUCTS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for non-parenteral vasopressin derivatives of posterior pituitary hormone products. No PA is required for members 6 years of age or older when dosed within established quantity limits for desmopressin acetate tablets. Payment for 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.

Preferred

- Desmopressin Nasal Spray
Desmopressin Tablets
Stimate Nasal Spray

Non-Preferred

- DDAVP Acetate Nasal Spray
DDAVP Tablets

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

- Diabetes insipidus
Von Willebrand's disease
Nocturnal enuresis\*
Hemophilia A
Other (please specify)

\*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.

Form with fields for Prescriber signature (Must match prescriber listed above.) and 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.