Wellpoint

Desmopressin Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-474-3341.

1. Patient information	2. Physician information
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	4. Strength	5. Directions	6. Quantity per 30 days
☐ DDAVP	☐ 0.1 mg tablet ☐ 0.2 mg tablet ☐ 4 mcg/mL ampul ☐ 4 mcg/mL vial		Specify:
☐ desmopressin acetate	☐ 0.1 mg tablet ☐ 0.2 mg tablet ☐ 4 mcg/mL vial		
7. Diagnosis:			

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

All requests ☐ Yes ☐ No Patient has a diagnosis of moderate to severe renal impairment in the last 365 days
Requests for oral DDAVP (desmopressin acetate): ☐ Yes ☐ No Patient has a diagnosis of primary nocturnal enuresis or diabetes insipidus in the last 730 days
Requests for injectable DDAVP (desmopressin acetate): ☐ Yes ☐ No Patient has a diagnosis of diabetes insipidus, hemophilia, or Von Willebrand's disease in the last 730 days

☐ Yes ☐ No Patient has a history of anti-hemophilic factor agents in the last 730 days For the *Medicaid Preferred Drug List*, please refer to the Medicaid Vendor Drug Program website at **https://www.txvendordrug.com/formulary/formulary-search**
Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.
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