OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process may be delayed.**

Drug Requested: Nocdurna® (desmopressin) **sublingual tablets**

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable**: _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member is 18 years of age or older
- ❑ Prescribed by or in consultation with a urologist, geriatrician, or endocrinologist
- ❑ Member is awakening at least two times per night to void while using alternative desmopressin therapy, such as desmopressin oral tablets (trial may be waived for members > 65 years of age)
- ❑ Member has a diagnosis of nocturnal polyuria, as confirmed by a 24-hour urine collection, before treatment initiation and the member meets **ONE** of the following:
  - ❑ Nocturnal urine volume exceeds 20% of the total 24-hour urine volume in members < 65 years of age
  - ❑ Nocturnal urine volume exceeds 33% of the total 24-hour urine volume in members 65 years of age or older
- ❑ Member has 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)
- ❑ Member is **NOT** using the requested medication along with a loop diuretic (e.g., furosemide) or systemic/inhaled corticosteroids
- ❑ Member does **NOT** have any of the following: current or history of hyponatremia, syndrome of inappropriate antidiuretic hormone (SIADH), congestive heart failure (all classes), polydipsia, or uncontrolled hypertension
- ❑ Member does **NOT** have renal impairment (eGFR below 50 mL/min/1.73 m2)
- ❑ Member has serum sodium concentrations within the normal range of 135-145 mmol/L
- ❑ Provider has ruled out all possible resolvable underlying causes of nocturia and identified the correct underlying pathophysiologic cause of nocturia (such as bladder dysfunction, excessive nocturnal urine production including but not limited to obstructive sleep apnea, neurodegenerative disease, diabetes mellitus and insipidus, electrolyte deficiencies or excess, current medications, chronic kidney disease)

(Continued on next page)

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member continues to meet all initial authorization criteria
- ❑ Member has experienced a decrease in the number of nocturnal voids from baseline (prior to starting therapy with requested medication)
- ❑ Member has serum sodium concentrations within the normal range of 135-145 mmol/L
- ❑ Member continues to be monitored for hyponatremia, uncontrolled hypertension, renal impairment

Medication being provided by Specialty Pharmacy - PropriumRx

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Member Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by the Pharmacy and Therapeutics Committee:** 2/20/2020
REVISED/UPDATED: ~~6/11/2020;~~ **8/26/2022**;