Request for Prior Authorization
Nocturnal Polyuria Treatments

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (877) 733-3195
Provider Help Desk
1 (844) 236-1464

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for nocturnal polyuria agents. Payment will be considered for patients when the following criteria are met:

1) Patient meets the FDA approved age; and
2) Patient has a diagnosis of nocturnal polyuria as confirmed by a 24-hour collection which notes the presence of greater than 33% of 24-hour urine production occurring at night; and
3) Patient wakens at least 2 times at night to void; and
4) Patient has attempted fluid restriction in the evenings without improvement in nocturnal polyuria; and
5) Patient is not taking a diuretic in the evening; and
6) Patient does not have any of the following contraindications; and
   a) Current or previous history of hyponatremia; and
   b) Primary nocturnal enuresis; and
   c) Polydipsia; and
   d) Concomitant use with loop diuretics, systemic or inhaled glucocorticoids; and
   e) Known or suspected syndrome of inappropriate antidiuretic hormone (SIADH) secretion; and
   f) Estimated glomerular filtration rate < 50 mL/min/1.73 m_2; and
   g) Illnesses that can cause fluid or electrolyte imbalance; and
   h) New York Heart Association (NYHA) Class II-IV congestive heart failure; and
   i) Uncontrolled hypertension.

Initial requests will be considered for 3 months. Requests for continuation of therapy will require the following:

1) Patient continues to meet above criteria; and
2) Patient has experienced a decrease in nocturnal voiding; and
3) There is not evidence of toxicity (e.g., hyponatremia, fluid retention, or electrolyte imbalances).

Non-Preferred

☐ Nocdurna

Strength	Dosage Instructions	Quantity	Days Supply

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Diagnosis:_____

Was diagnosis confirmed by a 24-hour collection which notes 33% of 24-hour urine production occurring at night? ☐ Yes (attach results) ☐ No

☐ **Initial Requests:**

Does patient waken at least 2 times at night to void? ☐ Yes ☐ No

Has patient attempted fluid restriction in the evenings without improvement in nocturnal polyuria? ☐ Yes ☐ No

Is patient taking a diuretic in the evening? ☐ Yes ☐ No

Does patient have any of the following contraindications? ☐ Yes ☐ No

- Current or previous history of hyponatremia
- Primary nocturnal enuresis
- Polydipsia
- Concomitant use with loop diuretics, systemic or inhaled glucocorticoids
- Known or suspected syndrome of inappropriate antidiuretic hormone (SIADH) secretion
- Estimated glomerular filtration rate < 50 mL/min/1.73 m_2
- Illnesses that can cause fluid or electrolyte imbalance
- New York Heart Association (NYHA) Class II-IV congestive heart failure
- Uncontrolled hypertension

☐ **Renewal Requests (all criteria above, plus the following):**

Has patient experienced a decrease in nocturnal voiding? ☐ Yes ☐ No

Is there evidence of toxicity (e.g., hyponatremia, fluid retention, or electrolyte imbalance)? ☐ Yes ☐ No

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	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. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*