BlueCross BlueShield Federal Employee Program.

NOCDURNA / NOCTIVA PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Nocdurna / Noctiva

(desmopressin acetate)

NOTE: Form must be completed in its **entirety** for processing

Please select medication and indicate quantity:

❑ **Nocdurna quantity _____ tablet(s) every 90 days** ❑ **Noctiva quantity _____ bottle(s) every 90 days**

Is this request for brand or generic? ❑Brand ❑Generic

1. Does the patient have a diagnosis of nocturia due to nocturnal polyuria? ❑Yes ❑No
2. **Nocdurna Request:** Will Nocdurna be used in combination with Noctiva nasal spray? ❑Yes ❑No
3. **Noctiva Request**: Will Noctiva be used in combination with Nocdurna tablets? ❑Yes ❑No
4. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Select answer below:***

❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:

a. Does the patient have an average of at least two nocturic episodes per night? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one anticholinergic such as Detrol (tolterodine), Enablex (darifenacin), Oxytrol (oxybutynin), Sanctura (trospium) or Vesicare (solifenacin)? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one generic desmopressin product? ❑Yes ❑No

d. Does the patient have an estimated glomerular filtration rate (eGFR) greater than or equal to 50 mL/min/1.73 m^2? ❑Yes ❑No

e. Does the patient have normal serum sodium concentrations? ❑Yes***** ❑No

****If YES***, does the prescriber agree to monitor the patient's serum sodium? ❑Yes ❑No

❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

a. Has the patient had a decrease in nocturic episodes from baseline? ❑Yes ❑No

b. Does the prescriber agree to monitor the patient's serum sodium? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times***.

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.