



TEXAS MEDICAID Clinical Edit Prior Authorization desmopressin injectable (DDAVP)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING

Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: COMPLETE REQUIRED CRITERIA

Indicate Primary Diagnosis: _____ ICD 10 Code: _____

1. Does the client have a diagnosis of severe renal impairment in the last 365 days?
 Yes (Deny) No (Go to #2)

2. Does the client have a diagnosis of diabetes insipidus, hemophilia, or Von Willebrand's disease in the last 730 days?
 Yes (Go to #4) No (Go to #3)

3. Does the client have a history of an anti-hemophilic factors agent in the last 730 days?
Examples include ADVATE, ADYNOVATE, AFSTYLA, ALPHANATE, ELOCTATE, FEIBA NF, HELIXATE FS, HEMOFIL M, HUMATE-P, KOATE, KOGENATE FS, KOVALTRY, MONOCLATE-P, NOVOEIGHT, NUWIQ, NOVOSEVEN RT, RECOMBINATE, WILATE, and XYNTHA
 Yes (Go to #4) No (Deny)

4. Is the dose requested less than or equal to 1 mL per day?
 Yes (Approve – 365 Days) No (Deny)

STEP 3: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: 855-668-8553

Prescriber Signature: _____ Date: _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.