Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization
Injectable desmopressin (DDAVP)

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** ☐ **Standard (Non-Urgent)** *Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :	Specialty:	
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:

1. Medication Requested (Name):
(Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

Clinical Criteria (required)

6. Does the member have a diagnosis of moderate to severe renal impairment in the last 365 days?

- ◯ Yes (Deny)
  (Go to #7)
- ◯ No
  (Go to #7)

7. Does the member have a diagnosis of diabetes insipidus, hemophilia, or Von Willebrand's disease in the last 730 days?

- ◯ Yes
  (Go to #9)
- ◯ No
  (Go to #8)

8. Does the member have a history of an anti-hemophilic factors agent in the last 730 days?

- ◯ Yes
  (Go to #9)
- ◯ No (Deny)
  (Go to #9)

9. Is the dose requested less than or equal to (≤) 1 ml per day?

- ◯ Yes (Approve - 365 days)
  (Go to #10)
- ◯ No (Deny)
  (Go to #10)

Additional Information

10. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

**** PLEASE FAX COMPLETED FORM TO: 855-668-8553 ****

If criteria not met, submit chart documentation with form citing complex medical circumstances.
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