TEXAS MEDICAID
Clinical Edit Prior Authorization
desmopressin oral (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. Is the client less than (<) 18 years of age?

   ☐ Yes (Go to #3) ☐ No (Go to #2)

2. Does the client have a diagnosis of severe renal impairment in the last 365 days?

   ☐ Yes (Deny) ☐ No (Go to #3)

3. Does the client have a diagnosis of primary nocturnal enuresis or diabetes insipidus in the last 730 days?

   ☐ Yes (Go to #4) ☐ No (Deny)

4. Is the dose requested less than or equal to (≤) 0.8 mg 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.