



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

TEXAS MEDICAID

**Drug Prior Authorization
 Oral 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. Is the member less than (<) 18 years of age?

Yes
(Go to #8)

No
(Go to #7)

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

Yes (Deny)
(Go to #8)

No
(Go to #8)

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

Yes
(Go to #9)

No (Deny)
(Go to #9)

9. Is the dose requested less than or equal to (\leq) 0.8mg 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.
For questions, please call Customer Care at 877-908-6023

For questions, please call Navitus Customer Care at 1-877-908-6023.