# Nocdurna (desmopressin acetate) Sublingual Tablets

## Member and Medication Information (required)

<table>
<thead>
<tr>
<th>Member ID:</th>
<th>Member Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOB:</td>
<td>Weight:</td>
</tr>
<tr>
<td>Medication Name/ Strength:</td>
<td>Dose:</td>
</tr>
</tbody>
</table>

**Directions for use:**

## Provider Information (required)

<table>
<thead>
<tr>
<th>Name:</th>
<th>NPI:</th>
<th>Specialty:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Person:</td>
<td>Office Phone:</td>
<td>Office Fax:</td>
</tr>
</tbody>
</table>

All information to be legible, complete and correct or form will be returned. FAX DOCUMENTATION INCLUDING PROGRESS NOTES or UPDATED LETTER OF MEDICAL NECESSITY TO 855-828-4992

## Criteria for Approval (all of the following must be met):

- Is the patient at increased risk of severe hyponatremia?  
  - Yes  
  - No  
  
  - Please describe your protocol for managing hyponatremia: ____________________________

- Will the patient’s serum sodium will be measured within one week of initiating therapy, one month later, and periodically during treatment?  
  - Yes  
  - No

- Is the estimated glomerular filtration rate above 50 mL/min per 1.73 m²?  
  - Yes  
  - No

- Is the patient’s hypertension under control?  

- Has the patient had an adequate trial and failure of at least two preferred short-acting or long-acting urinary antispasmodics:
  1. Drug 1 Name and Dose: ____________________________
     - Duration of Trial: ____________________________
     - Details of trial results: ____________________________
  2. Drug 2 Name and Dose: ____________________________
     - Duration of Trial: ____________________________
     - Details of trial results: ____________________________

## Re-authorization Criteria:

Updated letter of medical necessity or updated chart notes demonstrating positive clinical response.

**Authorization:** Six (6) months  
**Re-authorization:** Up to one (1) year

## PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

Prescriber’s Signature ____________________________  
Date ____________________________