

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.

**This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.**

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____		

Section B - Provider Information

First Name:	Last Name:	M.D./D.O.	
Address:	City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax attention to:			

Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

**Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:
Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives**

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

ALL REQUESTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a diagnosis of nocturia due to nocturnal polyuria (as defined by nighttime urine production that exceeds one-third of the 24-hour urine production)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient wake at least twice per night on a reoccurring basis to void?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there documentation that the patient’s serum sodium level is currently within normal limits of the normal laboratory reference range and has been within normal limits over the previous six months? <i>If yes, list sodium levels and dates:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient been evaluated for other medical causes of nocturia (e.g. overactive bladder, benign prostatic hyperplasia/lower urinary tract symptoms (BPH/LUTS), elevated post-void residual urine, and heart failure)? (If yes, check which applies) <input type="checkbox"/> Patient evaluated and NO other medical causes found <input type="checkbox"/> Patient evaluated and other medical causes found <input type="checkbox"/> Has not been evaluated for other causes
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient either not responded to, not tolerated, or has a contraindication to treatments for identifiable medical causes? <i>If yes, list what patient meets:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the prescriber attest that the risks have been assessed and benefits outweigh the risks?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the prescriber provide a reason or special circumstance why the patient cannot use Nocdurna? <i>If yes, list reason or special circumstance:</i>

CONTINUATION OF THERAPY

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a documented positive clinical response to Noctiva or Nocdurna therapy? <i>If yes, list response:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have routine monitoring for serum sodium levels? <i>If yes, list sodium level and date:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the prescriber attest that the risks of hyponatremia have been assessed and benefits outweigh the risks?

Provider Signature: _____ **Date:** _____

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