UnitedHealthcare Community Plan

Noctiva & Nocdurna - Nebraska
Prior Authorization Request Form

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: □ New or □ Continuation of Therapy? If continuation, list start date: ______________

Is this patient currently hospitalized? □ Yes □ 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? □ Yes □ 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

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information	
ALL REQUESTS	
□ Yes □ 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)?**
□ Yes □ No	**Does the patient wake at least twice per night on a reoccurring basis to void?**
□ Yes □ 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?** *If yes, list sodium levels and dates:*
□ Yes □ 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)* □ Patient evaluated and NO other medical causes found □ Patient evaluated and other medical causes found □ Has not been evaluated for other causes
□ Yes □ No	**Has the patient either not responded to, tolerated, or has a contraindication to treatments for identifiable medical causes?** *If yes, list what patient meets:*
□ Yes □ No	**Does the prescriber attest that the risks have been assessed and benefits outweigh the risks?**
□ Yes □ No	**Does the prescriber provide a reason or special circumstance why the patient cannot use Nocdurna?** *If yes, list reason or special circumstance:*
CONTINUATION OF THERAPY	
□ Yes □ No	**Does the patient have a documented positive clinical response to Noctiva or Nocdurna therapy?** *If yes, list response:*
□ Yes □ No	**Does the patient have routine monitoring for serum sodium levels?** *If yes, list sodium level and date:*
□ Yes □ 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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