OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Noctiva™ Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:
❑ Nocturia due to nocturnal polyuria
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Does nighttime urine production exceed 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 the initial serum sodium level prior to initiating therapy within normal limits of the normal laboratory reference range? ❑ **Yes** ❑ **No**

Have underlying causes of nocturia been ruled out (e.g., overactive bladder, benign prostatic hyperplasia (BPH), Parkinson's disease, excessive bedtime fluid intake)? ❑ **Yes** ❑ **No**

Have underlying medical causes of nocturia been adequately treated prior to initiating therapy (e.g. use of alpha-adrenergic blockers or 5-alpha reductase inhibitors for BPH, vaginal estrogens for vaginal atrophy)? ❑ **Yes** ❑ **No**

Does the prescriber attest that the risks have been assessed and benefits outweigh the risks? ❑ **Yes** ❑ **No**

Reauthorization:

For reauthorization requests, also answer the following:

Is there documentation of positive clinical response to Noctiva therapy? ❑ **Yes** ❑ **No**

Does the patient have routine monitoring for serum sodium levels? ❑ **Yes** ❑ **No**

Has the patient demonstrated risks of hyponatremia? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Noctiva_CMS_2019Jan-W