



**Desmopressin  
injection  
(DDAVP)**

**Express Scripts  
Prior Authorization  
Phone 800-417-8164  
Fax 877-837-5922**

**Please have the information below ready when calling in the authorization.**

Member's Last Name	Member's First Name
VH ID number	Date of Birth
Prescriber's Name	Contact Person
Office phone	Office Fax

Medication:	Diagnosis:
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<p><b>1. Does the patient have a diagnosis of one of the following:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Central cranial diabetes insipidus</li><li><input type="checkbox"/> Hemophilia A</li><li><input type="checkbox"/> Von Willebrand's disease (type 1)</li></ul>
<p><b>2. Has the patient tried and failed oral and/or intranasal desmopressin? Please specify which one.</b></p>
<p><b>3. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?</b></p>

Notice: **Failure to provide all information requested on this form may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>.