

Unison Health Plan Pharmacy Department  
Pharmacy Medical Exception Request Worksheet  
Please complete and return via fax to 412-457-1328 or 866-639-7785



**DDAVP (Desmopressin)**

PATIENT NAME \_\_\_\_\_  
D.O.B. \_\_\_\_\_ MEMBER ID# \_\_\_\_\_  
DRUG REQUESTED \_\_\_\_\_  
DOSAGE and Sig. \_\_\_\_\_ # REFILLS \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_ PH# \_\_\_\_\_ FAX# \_\_\_\_\_  
PHYSICIAN ADDRESS \_\_\_\_\_  
[Office Stamp] \_\_\_\_\_  
\_\_\_\_\_

1. Patient diagnosis: - Nocturnal Enuresis  
- Other: \_\_\_\_\_

2. Did this patient receive DDAVP in the past? Circle: YES or NO

3. If YES to #2, please indicate when, what dose and duration of treatment:  
\_\_\_\_\_  
\_\_\_\_\_

4. If this patient has diagnosis of primary nocturnal enuresis and received treatment with DDAVP in past, did this patient have a trial off medication?  
Circle: YES or NO  
If yes, Please indicate when and for how long? \_\_\_\_\_  
\_\_\_\_\_

5. If YES to # 4, did the patient relapse? Circle: YES or NO

6. Additional information relevant to this patient's case \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The purpose of this worksheet is to provide complete information regarding the physician's request for a non-formulary or prior authorization medication. It will be reviewed and notification of approval or denial will be given within 24 hours. Thank you.

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