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#** ______________________ **DURATION** ___________

DRUG REQUESTED____

DOSAGE and Sig. ___________________________________ **FAX ATTENTION:**_______________

PHYSICIAN (PLEASE PRINT)____________________ **PH# (___)**_________ **FAX# (___)**___________

PHYSICIAN ADDRESS ____

____

Please Note*: *ALL are required fields above

<< Additional Drug Specific forms are available at UnisonHealthPlan.com >>

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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