Texas Prior Authorization Program
Clinical Criteria

Drug/Drug Class

Desmopressin

Clinical Criteria Information Included in this Document

Desmopressin - Oral

- **Drugs requiring prior authorization**: the list of drugs requiring prior authorization for this clinical criteria
- **Prior authorization criteria logic**: a description of how the prior authorization request will be evaluated against the clinical criteria rules
- **Logic diagram**: a visual depiction of the clinical criteria logic
- **Supporting tables**: a collection of information associated with the steps within the criteria (diagnosis codes, procedure codes, and therapy codes); provided when applicable
- **References**: clinical publications and sources relevant to this clinical criteria

Desmopressin - Injectable

- **Drugs requiring prior authorization**: the list of drugs requiring prior authorization for this clinical criteria
- **Prior authorization criteria logic**: a description of how the prior authorization request will be evaluated against the clinical criteria rules
- **Logic diagram**: a visual depiction of the clinical criteria logic
- **Supporting tables**: a collection of information associated with the steps within the criteria (diagnosis codes, procedure codes, and therapy codes); provided when applicable
- **References**: clinical publications and sources relevant to this clinical criteria

Note: Click the hyperlink to navigate directly to that section.

Revision Notes

Updated ICD-10 codes for dialysis in supporting table 1 for desmopressin oral agents

Desmopressin
Oral
Drugs Requiring Prior Authorization

The listed GCNS may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
DDAVP 0.1 MG TABLET	26171
DDAVP 0.2 MG TABLET	26172
DESMOPRESSIN ACETATE 0.1 MG TB	26171
DESMOPRESSIN ACETATE 0.2 MG TB	26172

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Desmopressin Oral

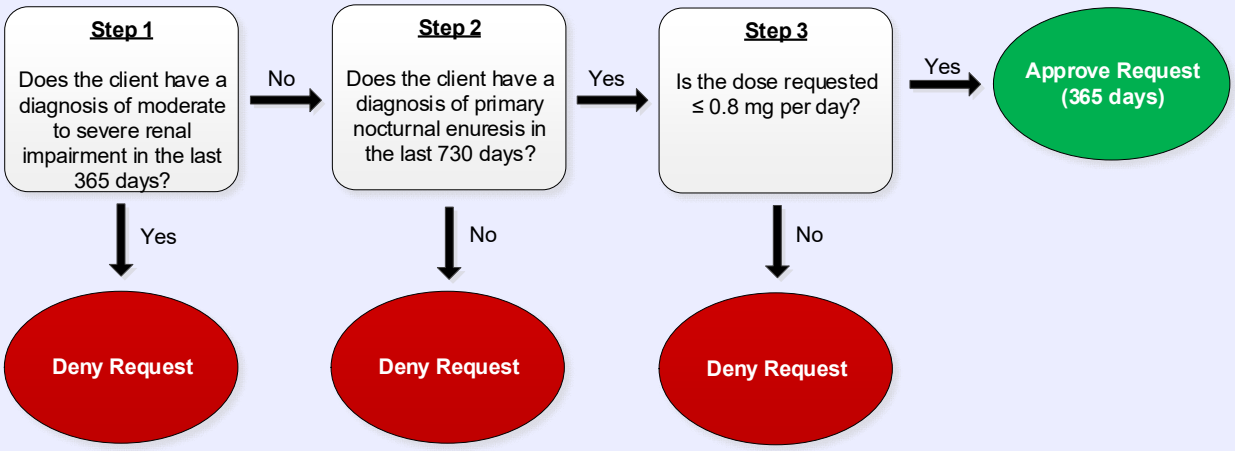
Clinical Criteria Logic

1. Does the client have a diagnosis of **moderate to severe renal impairment** in the last 365 days?
   [ ] Yes (Deny)
   [ ] No (Go to #2)

2. Does the client have a diagnosis of **primary nocturnal enuresis or diabetes insipidus** in the last 730 days?
   [ ] Yes (Go to #3)
   [ ] No (Deny)

3. Is the dose requested less than or equal to (≤) 0.8mg per day?
   [ ] Yes (Approve – 365 days)
   [ ] No (Deny)

Desmopressin
Oral
Clinical Criteria Logic Diagram



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Desmopressin
Oral
Clinical Criteria Supporting Tables

Step 1 (diagnosis of moderate to severe renal impairment) **Required diagnosis:** *1* **Look back timeframe:** *365 days*	
ICD-10 Code	**Description**
I120	HYPERTENSIVE CHRONIC KIDNEY DISEASE WITH STAGE 5 CHRONIC KIDNEY DISEASE OR END STAGE RENAL DISEASE
I129	HYPERTENSIVE CHRONIC KIDNEY DISEASE WITH STAGE 1 THROUGH STAGE 4 CHRONIC KIDNEY DISEASE, OR UNSPECIFIED CHRONIC KIDNEY DISEASE
N010	RAPIDLY PROGRESSIVE NEPHRITIC SYNDROME WITH MINOR GLOMERULAR ABNORMALITY
N011	RAPIDLY PROGRESSIVE NEPHRITIC SYNDROME WITH FOCAL AND SEGMENTAL GLOMERULAR LESIONS
N012	RAPIDLY PROGRESSIVE NEPHRITIC SYNDROME WITH DIFFUSE MEMBRANOUS GLOMERULONEPHRITIS
N013	RAPIDLY PROGRESSIVE NEPHRITIC SYNDROME WITH DIFFUSE MESANGIAL PROLIFERATIVE GLOMERULONEPHRITIS
N014	RAPIDLY PROGRESSIVE NEPHRITIC SYNDROME WITH DIFFUSE ENDOCAPILLARY PROLIFERATIVE GLOMERULONEPHRITIS
N015	RAPIDLY PROGRESSIVE NEPHRITIC SYNDROME WITH DIFFUSE MESANGIOCAPILLARY GLOMERULONEPHRITIS
N016	RAPIDLY PROGRESSIVE NEPHRITIC SYNDROME WITH DENSE DEPOSIT DISEASE
N017	RAPIDLY PROGRESSIVE NEPHRITIC SYNDROME WITH DIFFUSE CRESCENTIC GLOMERULONEPHRITIS
N018	RAPIDLY PROGRESSIVE NEPHRITIC SYNDROME WITH OTHER MORPHOLOGIC CHANGES
N019	RAPIDLY PROGRESSIVE NEPHRITIC SYNDROME WITH UNSPECIFIED MORPHOLOGIC CHANGES
N038	CHRONIC NEPHRITIC SYNDROME WITH OTHER MORPHOLOGIC CHANGES
N059	UNSPECIFIED NEPHRITIC SYNDROME WITH UNSPECIFIED MORPHOLOGIC CHANGES
N1830	CHRONIC KIDNEY DISEASE, STAGE 3 UNSPECIFIED
N1831	CHRONIC KIDNEY DISEASE, STAGE 3A
N1832	CHRONIC KIDNEY DISEASE, STAGE 3B
N184	CHRONIC KIDNEY DISEASE, STAGE 4 (SEVERE)
N185	CHRONIC KIDNEY DISEASE, STAGE 5
N186	END STAGE RENAL DISEASE
N189	CHRONIC KIDNEY DISEASE, UNSPECIFIED

Step 1 (diagnosis of moderate to severe renal impairment) **Required diagnosis:** *1* **Look back timeframe:** *365 days*	
ICD-10 Code	**Description**
N261	ATROPHY OF KIDNEY (TERMINAL)
N269	RENAL SCLEROSIS, UNSPECIFIED
Z4901	ENCOUNTER FOR FITTING AND ADJUSTMENT OF EXTRACORPOREAL DIALYSIS CATHETER
Z4902	ENCOUNTER FOR FITTING AND ADJUSTMENT OF PERITONEAL DIALYSIS CATHETER
Z4931	ENCOUNTER FOR ADEQUACY TESTING FOR HEMODIALYSIS
Z4932	ENCOUNTER FOR ADEQUACY TESTING FOR PERITONEAL DIALYSIS
Z992	DEPENDENCE ON RENAL DIALYSIS

Step 2 (diagnosis of primary nocturnal enuresis or diabetes insipidus) **Required diagnosis:** *1* **Look back timeframe:** *730 days*	
ICD-10 Code	**Description**
E871	HYPO-OSMOLALITY AND HYPONATREMIA
E232	DIABETES INSIPIDUS
N393	STRESS INCONTINENCE (FEMALE) (MALE)
N3941	URGE INCONTINENCE
N3942	INCONTINENCE WITHOUT SENSORY AWARENESS
N3943	POST-VOID DRIBBLING
N3944	NOCTURNAL ENURESIS
N3945	CONTINUOUS LEAKAGE
N3946	MIXED INCONTINENCE
N39490	OVERFLOW INCONTINENCE
N39498	OTHER SPECIFIED URINARY INCONTINENCE
R32	UNSPECIFIED URINARY INCONTINENCE
R351	NOCTURIA
R3581	NOCTURNAL POLYURIA

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Drugs Requiring Prior Authorization

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Drugs Requiring Prior Authorization	
Label Name	**GCN**
DDAVP 4 MCG/ML AMPUL	10860
DDAVP 4 MCG/ML VIAL	10260
DESMOPRESSIN AC 4 MCG/ML VL	10260

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Clinical Criteria Logic

1. Does the client have a diagnosis of **moderate to severe renal impairment** in the last 365 days?
   [ ] Yes (Deny)
   [ ] No (Go to #2)

2. Does the client have a diagnosis of **diabetes insipidus, hemophilia, or Von Willebrand's disease** in the last 730 days?
   [ ] Yes (Go to #4)
   [ ] No (Go to #3)

3. Does the client have a history of an **anti-hemophilic factors agent** in the last 730 days?
   [ ] Yes (Go to #4)
   [ ] No (Deny)

4. Is the dose requested less than or equal to (≤) 1 ml per day?
   [ ] Yes (Approve - 365 days)
   [ ] No (Deny)

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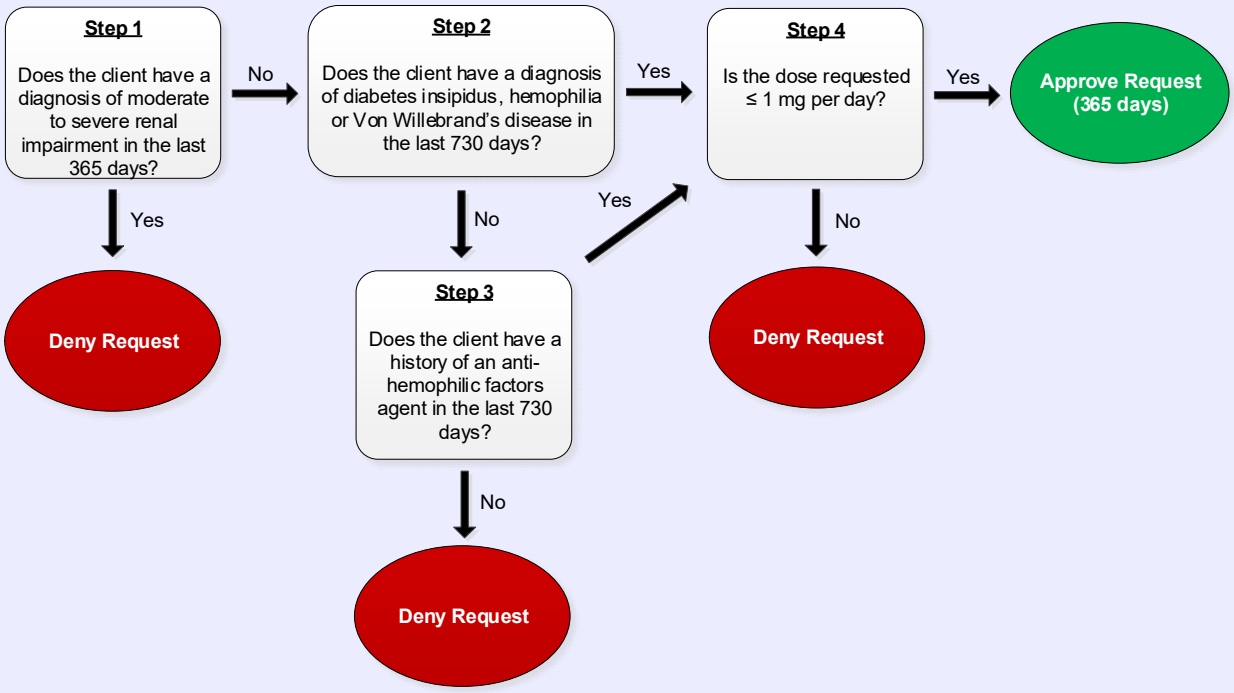
Clinical Criteria Logic Diagram



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Desmopressin Injectable

Clinical Criteria Supporting Tables

Step 1 (diagnosis of moderate to severe renal impairment) **Required diagnosis:** *1* **Look back timeframe:** *365 days*	
ICD-10	**Description**
I120	HYPERTENSIVE CHRONIC KIDNEY DISEASE WITH STAGE 5 CHRONIC KIDNEY DISEASE OR END STAGE RENAL DISEASE
I129	HYPERTENSIVE CHRONIC KIDNEY DISEASE WITH STAGE 1 THROUGH STAGE 4 CHRONIC KIDNEY DISEASE, OR UNSPECIFIED CHRONIC KIDNEY DISEASE
N010	RAPIDLY PROGRESSIVE NEPHRITIC SYNDROME WITH MINOR GLOMERULAR ABNORMALITY
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N015	RAPIDLY PROGRESSIVE NEPHRITIC SYNDROME WITH DIFFUSE MESANGIOCAPILLARY GLOMERULONEPHRITIS
N016	RAPIDLY PROGRESSIVE NEPHRITIC SYNDROME WITH DENSE DEPOSIT DISEASE
N017	RAPIDLY PROGRESSIVE NEPHRITIC SYNDROME WITH DIFFUSE CRESCENTIC GLOMERULONEPHRITIS
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N184	CHRONIC KIDNEY DISEASE, STAGE 4 (SEVERE)
N185	CHRONIC KIDNEY DISEASE, STAGE 5
N186	END STAGE RENAL DISEASE
N189	CHRONIC KIDNEY DISEASE, UNSPECIFIED

Step 1 (diagnosis of moderate to severe renal impairment) **Required diagnosis:** *1* **Look back timeframe:** *365 days*	
N261	ATROPHY OF KIDNEY (TERMINAL)
N269	RENAL SCLEROSIS, UNSPECIFIED

Step 2 (diagnosis of diabetes insipidus, hemophilia, or Von Willebrand's disease) **Required diagnosis:** *1* **Look back timeframe:** *730 days*	
ICD-10 Code	**Description**
D66	HEREDITARY FACTOR VIII DEFICIENCY
D680	VON WILLEBRAND'S DISEASE
E232	DIABETES INSIPIDUS

Step 3 (history of an anti-hemophilic factors agent) **Required quantity:** *1* **Look back timeframe:** *730 days*	
Label Name	**GCN**
ADVATE 1,201-1,800 UNITS VIAL	98830
ADVATE 1,801-2,400 UNITS VIAL	98764
ADVATE 2,401-3,600 UNITS VIAL	98634
ADVATE 200-400 UNITS VIAL	98833
ADVATE 3,601-4,800 UNITS VIAL	32723
ADVATE 401-800 UNITS VIAL	98831
ADVATE 801-1,200 UNITS VIAL	98832
ADYNOVATE 1,251-2,500 UNIT VIAL	40213
ADYNOVATE 1,500 UNIT VIAL	43013
ADYNOVATE 200-400 UNIT VIAL	40207
ADYNOVATE 3,000 UNIT VIAL	43353
ADYNOVATE 401-800 UNIT VIAL	40208
ADYNOVATE 750 UNIT VIAL	43009
ADYNOVATE 801-1,250 UNIT VIAL	40209
AFSTYLA 1,000 UNIT VIAL	41501
AFSTYLA 2,000 UNIT VIAL	41502
AFSTYLA 250 UNIT VIAL	41497
AFSTYLA 3,000 UNIT VIAL	41503
AFSTYLA 500 UNIT VIAL	41499
ALPHANATE 1,000-400 UNIT VIAL	27334
ALPHANATE 1,500-600 UNIT VIAL	27335

Step 3 (history of an anti-hemophilic factors agent) **Required quantity:** *1* **Look back timeframe:** *730 days*	
Label Name	**GCN**
ALPHANATE 2,000-800 UNIT VIAL	37015
ALPHANATE 250-100 UNIT VIAL	27332
ALPHANATE 500-200 UNIT VIAL	27333
ALPHANINE SD 500 UNIT VIAL	91671
ALPHANINE SD 1,000 UNIT VIAL	91672
ALPHANINE SD 1,500 UNIT VIAL	21647
ALPROLIX 500 UNIT NOMINAL	36333
ALPROLIX 1,000 UNIT NOMINAL	36334
ALPROLIX 2,000 UNIT NOMINAL	36335
ALPROLIX 3,000 UNIT NOMINAL	36336
ALPROLIX 250 UNIT NOMINAL	40816
ALPROLIX 4,000 UNIT NOMINAL	42556
AMICAR 500 MG TABLET	25590
AMICAR 1,000 MG TABLET	23444
AMICAR 0.25 GM/ML ORAL SOLN	25580
BENEFIX 250 UNIT RANGE	34868
BENEFIX 500 UNIT RANGE	34869
BENEFIX 1,000 UNIT RANGE	34873
BENEFIX 2,000 UNIT RANGE	34874
BENEFIX 3,000 UNIT RANGE	34875
CORIFACT KIT	29584
ELOCTATE 1,000 UNIT NOMINAL	36663
ELOCTATE 1,500 UNIT NOMINAL	36664
ELOCTATE 2,000 UNIT NOMINAL	36665
ELOCTATE 250 UNIT NOMINAL	36657
ELOCTATE 3,000 UNIT NOMINAL	36666
ELOCTATE 4,000 UNIT NOMINAL	43115
ELOCTATE 5,000 UNIT NOMINAL	43116
ELOCTATE 500 UNIT NOMINAL	36658
ELOCTATE 6,000 UNIT NOMINAL	43114
ELOCTATE 750 UNIT NOMINAL	36662
FEIBA NF 500 UNIT (NOMINAL)	23816
FEIBA NF 1,000 UNIT (NOMINAL)	23815
FEIBA NF 2,500 UNIT (NOMINAL)	26335
HELIXATE FS 1,000 UNIT VIAL	98832
HELIXATE FS 2,000 UNIT VIAL	98764

Step 3 (history of an anti-hemophilic factors agent) **Required quantity:** *1* **Look back timeframe:** *730 days*	
Label Name	**GCN**
HELIXATE FS 250 UNIT VIAL	98833
HELIXATE FS 3,000 UNITS VIAL	98634
HELIXATE FS 500 UNIT VIAL	98831
HEMLIBRA 30 MG/ML VIAL	44104
HEMLIBRA 60 MG/0.4 ML VIAL	44105
HEMLIBRA 105 MG/0.7 ML VIAL	44106
HEMLIBRA 150 MG/ML VIAL	44107
HEMOFIL M 1,000 UNIT NOMINAL	30193
HEMOFIL M 1,700 UNIT NOMINAL	30194
HEMOFIL M 250 UNIT NOMINAL	26777
HEMOFIL M 500 UNIT NOMINAL	26778
HUMATE-P 1,200 UNIT VWF:RCO	26451
HUMATE-P 2,400 UNIT VWF:RCO	26450
HUMATE-P 600 UNIT VWF:RCO	26449
IDELVION 250 UNIT VIAL	40749
IDELVION 500 UNIT VIAL	40751
IDELIVION 1,000 UNIT VIAL	40752
IDELVION 2,000 UNIT VIAL	40753
IDELVION 3,500 UNIT VIAL	44859
KOATE 1,000 UNIT VIAL	25129
KOATE 250 UNIT VIAL	25151
KOATE 500 UNIT VIAL	25132
KOGENATE FS 1,000 UNITS VIAL	98832
KOGENATE FS 2,000 UNITS VIAL	98764
KOGENATE FS 250 UNIT VIAL	98833
KOGENATE FS 3,000 UNITS VIAL	98634
KOGENATE FS 500 UNIT VIAL	98831
KOVALTRY 1,000 UNIT KIT	98832
KOVALTRY 2,000 UNIT KIT	98764
KOVALTRY 250 UNIT KIT	98833
KOVALTRY 3,000 UNIT KIT	98634
KOVALTRY 500 UNIT KIT	98831
LYSTEDA 650 MG TABLET	28578
MONOCLATE-P 1,000 UNIT KIT	25129
MONOCLATE-P 1,500 UNIT KIT	25131
NOVOEIGHT 1,000 UNIT VIAL	37395

Step 3 (history of an anti-hemophilic factors agent) **Required quantity:** *1* **Look back timeframe:** *730 days*	
Label Name	**GCN**
NOVOEIGHT 1,500 UNIT VIAL	37396
NOVOEIGHT 2,000 UNIT VIAL	37397
NOVOEIGHT 250 UNIT VIAL	37393
NOVOEIGHT 3,000 UNIT VIAL	37398
NOVOEIGHT 500 UNIT VIAL	37394
NUWIQ 1,000 UNIT VIAL PACK	38025
NUWIQ 2,000 UNIT VIAL PACK	38027
NUWIQ 2,500 UNIT VIAL PACK	43791
NUWIQ 250 UNIT VIAL PACK	38023
NUWIQ 3,000 UNIT VIAL PACK	43792
NUWIQ 4,000 UNIT VIAL PACK	43793
NUWIQ 500 UNIT VIAL PACK	38024
NOVOSEVEN RT 1MG VIAL	99696
NOVOSEVEN RT 2MG VIAL	99697
NOVOSEVEN RT 5MG VIAL	99698
NOVOSEVEN RT 8MG VIAL	29034
REBINYN 1,000 UNIT VIAL	43483
REBINYN 2,000 UNIT VIAL	43484
REBINYN 500 UNIT VIAL	43442
RECOMBINATE 1,241-2,400 UNIT V	27008
RECOMBINATE 1,801-2,400 UNIT V	26818
RECOMBINATE 220-400 UNIT VIAL	25123
RECOMBINATE 401-800 UNIT VIAL	25125
RECOMBINATE 801-1,240 UNIT VL	25124
TRETTEN 2,500 UNIT VIAL	35833
VONVENDI 650 UNIT VIAL	40278
VONVENDI 1,300 UNIT VIAL	40279
WILATE 1,000-1,000 UNIT KIT	32239
WILATE 500-500 UNIT KIT	32238
XYNTHA 1,000 UNIT KIT	99872
XYNTHA 2,000 UNIT KIT	99873
XYNTHA 250 UNIT KIT	99870
XYNTHA 500 UNIT KIT	99871
XYNTHA SOLOFUSE 1,000 UNIT KIT	30439
XYNTHA SOLOFUSE 2,000 UNIT KIT	30441
XYNTHA SOLOFUSE 250 UNIT KIT	31205

Step 3 (history of an anti-hemophilic factors agent) **Required quantity:** *1* **Look back timeframe:** *730 days*	
Label Name	**GCN**
XYNTHA SOLOFUSE 3,000 UNIT KIT	29387
XYNTHA SOLOFUSE 500 UNIT KIT	31206

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Desmopressin

Clinical Criteria References

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Publication History

The Publication History records the publication iterations and revisions to this document. Notes for the *most current revision* are also provided in the **Revision Notes** on the first page of this document.

Publication Date	Notes
05/24/2012	Initial publication and posting to website
10/25/2013	Changed "DM" to "diabetes insipidus" in step 3 of the clinical edit criteria logic and the logic diagram for Desmopressin – Oral
04/03/2015	Updated to include ICD-10s
05/08/2017	Annual review by staff Updated Table 4, page 15 Updated References, page 17
03/27/2019	Updated to include formulary statement (The listed GCNS may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.) on each 'Drug Requiring PA' table
12/21/2020	Removed check for hyponatremia from criteria logic and logic diagram
10/18/2022	Annual review by staff Added ICD-10 codes R351 (nocturia) and R3581 (nocturnal polyuria) to Table 2, desmopressin oral agents Added GCNs for Alphanine vials (91671,91672, 21647), Alprolix (36333,36334,36335,36336,40816,42556), Amicar (25590,23444, 25580), Benefix (34868, 34869, 34873, 34874, 34875), Corifact (29584), Hemlibra (44104, 44105, 44106, 44107), Idelvion (40749,40751, 40752, 40753, 44859), Lysteda (28578), Rebinyn (43483, 43484, 43442), Tretten (35833), and Vonvendi (40278, 40279) to Table 3 Updated severe renal impairment to moderate to severe renal impairment for question 1 for oral and injectable desmopressin Updated references
02/01/2023	Updated ICD-10 codes for dialysis in supporting table 1 for desmopressin oral agents