



1 Patient Information

Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical).

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs. kg.

Allergies: _____ Patient Primary Language: English Spanish Other: _____ Hearing Impaired

Patient Phone: _____ Patient Email: _____ Caregiver Name: _____

Patient Address: _____ City: _____ State: _____ Zip: _____



2 Diagnosis/Clinical Information

Please FAX Clinical Notes, Labs, & Tests with the prescription to expedite Prior Authorization.

Diagnosis/ICD-10:

R35.1 Nocturia R35.8 Other Polyuria R35.81 Nocturnal Polyuria Other: _____

How many voids per night for the last 6 months? _____

Have lifestyle changes been made to avoid nocturia: Yes No

Has the patient had any of the following in the last 6 months:

- Renal Impairment (eFGR less than 50mL/min) Uncontrolled Hypertension Polydipsia
- Hyponatremia or History of Hyponatremia Uncontrolled Diabetes Mellitus Nocturnal Enuresis
- Chronic Prostatitis/Pelvic Pain Syndrome Interstitial Cystitis SIADH
- Bladder Outlet Obstruction (BOO) Congestive Heart Failure

Diagnosis Procedure(s) or Laboratory Test(s):

Test/Procedure:	Date Performed:	Results:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Prior Failed Treatments: Must be completed for all patients.

Treatment Type	Drug Name	Dates of Use
Detrol/Detrol LA	_____	_____
DDAVP Tablet	_____	_____
Enablex	_____	_____
Myrbetriq	_____	_____
Oxybutynin	_____	_____
Toviaz	_____	_____
Trospium Chloride	_____	_____
VESicare	_____	_____
Other:	_____	_____

Black Box Warning:

Patient and prescriber are aware of Black Box Warning, and prescriber views the benefits to outweigh the risks.

Provider has determined that the alternative treatment options would not be as effective as the prescribed medication, and therefore the requested medication is medically necessary.



3 Prescription Information

Please be sure to choose both induction and maintenance dose where applicable.

Medication	Dose/Strength	Direction	Qty.	Refills
NOCDURNA®	27.7mcg (Female) 55.3mcg (Male)	Dissolve 1 tablet under tongue every night at bedtime. Other: _____	30	_____
_____	_____	_____	_____	_____



4 Provider/Prescriber Information

Clinic Name: _____ Provider Name: _____

Provider Phone: _____ Provider Fax: _____ DEA#: _____ NPI#: _____

Provider Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: Prescriber, please sign and date below (**NO stamps please**):

Signature: _____ Date: _____ Dispense as Written (Write "DAW")

I authorize Sterling Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance Prior Authorization process, nursing services, and patient assistance programs. IMPORTANT NOTICE: This fax is intended to be delivered to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.