**Stimate (von Willebrand's disease, hemophilia A)**

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| Criteria 1 | Stimate (von Willebrand's disease, hemophilia A) |

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| **Criteria Title** | Nasal synthetic vasopressin analogue | | |
| **Criteria Subtitle** | Stimate (desmopressin acetate) | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**     |  |  | | --- | --- | | Preferred |  | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| STIMATE | 022139 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 1001 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 1002 |
| Continuation (re-authorization request) | 1234 |
| 2 | 1002 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1003 |
| N | 1235 |
| 3 | 1003 |  | Select and Free Text | Has the provider submitted documentation of a Stimate challenge test performed prior to initiation of therapy? | Y | END (Approve x 30 days) |
| N | 1235 |
| 4 | 1234 |  | Select and Free Text | Has the provider submitted documentation of clinical response? | Y | END (Approve x 365 days) |
| N | 1235 |
| 5 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: Initial authorizations will be for 30 days; Subsequent authorizations will be for 365 days

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| **Last Approved** | 4/13/2023 |
| **Other** |  |