SENTARA COMMUNITY PLAN (MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

<u>Directions</u>: <u>The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request</u>. All other information may be filled in by office staff; <u>fax to 1-800-750-9692</u>. No additional phone calls will be necessary if all information (<u>including phone and fax #s</u>) on this form is correct. <u>If the information provided is not complete, correct, or legible, the authorization process can be delayed.</u>

Drug Requested: Northera® (droxidopa)

MEMBER & PRESCRIBER IN	NFORMATION: Authorization may be delayed if incomplete.
Member Name:	
Member Sentara #:	Date of Birth:
Prescriber Name:	
Prescriber Signature:	Date:
Office Contact Name:	
Phone Number:	Fax Number:
DEA OR NPI #:	
DRUG INFORMATION: Autho	orization may be delayed if incomplete.
Drug Form/Strength:	
Dosing Schedule:	Length of Therapy:
Diagnosis	ICD Code, if applicable:
Diagnosis:	ICD Couc, if applicable.
Weight:	
Weight:CLINICAL CRITERIA: Check l	
Weight:CLINICAL CRITERIA: Check to support each line checked, all document	below all that apply. All criteria must be met for approval. To natation, including lab results, diagnostics, and/or chart notes, must be
Weight: CLINICAL CRITERIA: Check I support each line checked, all documen provided or request may be denied.	below all that apply. All criteria must be met for approval. To natation, including lab results, diagnostics, and/or chart notes, must be the contract of the
Weight: CLINICAL CRITERIA: Check I support each line checked, all documen provided or request may be denied. Authorization Approval Length 1) Diagnosis of neurogenic orthosta	below all that apply. All criteria must be met for approval. To natation, including lab results, diagnostics, and/or chart notes, must be the contract of the
Weight: CLINICAL CRITERIA: Check Is support each line checked, all document provided or request may be denied. Authorization Approval Length 1) Diagnosis of neurogenic orthostate 2) Prior failure on each of the other	below all that apply. All criteria must be met for approval. To station, including lab results, diagnostics, and/or chart notes, must be stic hypotension (NOH)? Three (3) months

^{** &}lt;u>Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.</u> **

*<u>Previous therapies will be verified through pharmacy paid claims or submitted chart notes.</u> *