

SENTARAHEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

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

Drug Requested: droxidopa (Northera®)

MEMBER & PRESCRIBER INFORMATION: 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: Complete information below or authorization will be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight: _____ Date: _____

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation including labs or chart notes (if required) **must** be submitted or request will be denied.

• Prescriber is: Specialist Cardiologist

1. Does the patient have orthostatic dizziness or lightheadedness associated with orthostatic hypotension caused by primary autonomic failure (Parkinson Disease), multiple system atrophy, or pure autonomic failure? Yes No

2. Does the patient have dopamine beta-hydroxylase deficiency or non-diabetic autonomic neuropathy? Yes No

3. Does the patient have any cardiac issues such as hypertension, cardiovascular risk factors, or coronary artery disease? Yes No

4. Does the patient have any documented history of cardiovascular attacks? Yes No

5. Will supine blood pressure be monitored during therapy? Yes No

(Continued on next page)

AND

- Patient has tried and failed **ALL** of the following:

midodrine **AND** fludrocortisone

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.