OPTIMA FAMILY CARE MEDALLION 4.0

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. Incomplete form will delay authorization process.***

Drug Requested: **Northera**® (droxidopa)

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable***: _____

***CLINICAL CRITERIA*: *ALL* boxes *must* be checked to qualify or authorization process will be delayed. Chart notes *MUST* be attached to this request.**

- **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**

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.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***REVISED/UPDATED: 7/1/2018**