OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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 or 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 to ensure authorization process will **NOT** 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

(continued on next page; signature page MUST be attached to this request.)

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*****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:** ~~8/26/2017;~~ **8/27/2018**