OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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: 8/26/2017**