

# NORTHERA

## PRIOR AUTHORIZATION REQUEST

### PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit [www.myprime.com](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermymeds.com](http://covermymeds.com) to begin using this free service.

What is the priority level of this request?

- Standard review  
 Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: \_\_\_\_\_

#### PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today's Date): \_\_\_\_\_

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

#### PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

#### PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's diagnosis:  
 Neurogenic orthostatic hypotension (nOH)  
 Other (ICD code plus description): \_\_\_\_\_

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

**For all requests:**

- Is the patient currently treated with the requested agent? .....  Yes  No  
 If yes, is the patient currently stable on the requested agent? **Please note, chart notes are required.** .....  Yes  No
- Is the patient's age within FDA labeling for the requested indication for the requested agent? .....  Yes  No  
 If no, please provide support for using the requested agent for the patient's age for the requested indication: \_\_\_\_\_
- Does the patient have any FDA labeled contraindications to the requested agent? .....  Yes  No  
 If yes, please specify FDA labeled contraindications: \_\_\_\_\_
- Is the prescriber a specialist in the area of the patient's diagnosis (e.g., cardiologist, neurologist), or has the prescriber consulted with a specialist? .....  Yes  No
- Has the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? .....  Yes  No
- Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? .....  Yes  No
- If yes to either of the previous two questions, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? .....  Yes  No
- Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please continue to the next page.**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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**For brand Northera requests:**

9. Is there support for the use of the requested brand agent over the generic equivalent, droxidopa? .....  Yes  No

If yes, please provide supporting information: \_\_\_\_\_  
 \_\_\_\_\_

• **Please submit chart notes to support the answers to the following questions:**

10. Has the patient tried and had an inadequate response to the generic equivalent, droxidopa?.....  Yes  No

11. Was the generic equivalent, droxidopa, discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No

12. Does the patient have an intolerance or hypersensitivity to the generic equivalent, droxidopa, that is not expected to occur with the requested brand agent? .....  Yes  No

13. Does the patient have an FDA labeled contraindication to the generic equivalent, droxidopa, that is not expected to occur with the requested brand agent? .....  Yes  No

14. Is the generic equivalent, droxidopa, expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; or cause a significant barrier to the patient's adherence of care; or worsen a comorbid condition; or decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; or cause an adverse reaction or cause physical or mental harm? .....  Yes  No

15. Is the generic equivalent, droxidopa, not in the best interest of the patient based on medical necessity? .....  Yes  No

16. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as the generic equivalent, droxidopa, and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No

**For neurogenic orthostatic hypotension (nOH) requests:**

17. Has the prescriber performed baseline (prior to therapy with the requested agent) blood pressure readings while the patient is sitting or supine (laying face up) AND also within 3 minutes of standing from a supine position? .....  Yes  No

18. Does the patient have a decrease of at least 20 mmHg in systolic blood pressure or 10 mmHg diastolic blood pressure within three minutes after standing? .....  Yes  No

19. Does the patient have persistent and consistent symptoms of neurogenic orthostatic hypotension (nOH) caused by one of the following: 1) primary autonomic failure [Parkinson's disease (PD)], multiple system atrophy, or pure autonomic failure), 2) dopamine beta-hydroxylase deficiency, or 3) non-diabetic autonomic neuropathy?.....  Yes  No

20. Has the prescriber assessed the severity of the patient's baseline (prior to therapy with the requested agent) symptoms of dizziness, lightheadedness, feeling faint, or feeling like the patient may black out? .....  Yes  No

21. Has the prescriber assessed and adjusted, if applicable, any medications known to exacerbate orthostatic hypotension (e.g., diuretics, vasodilators, beta-blockers)? .....  Yes  No

• **Please submit chart notes to support the answers to the following questions:**

22. Has the patient tried and had an inadequate response to midodrine?.....  Yes  No

23. Was midodrine discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ..  Yes  No

24. Does the patient have an intolerance or hypersensitivity to midodrine? .....  Yes  No

25. Does the patient have an FDA labeled contraindication midodrine? .....  Yes  No

26. Is midodrine expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; or cause a significant barrier to the patient's adherence of care; or worsen a comorbid condition; or decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; or cause an adverse reaction or cause physical or mental harm? .....  Yes  No

27. Is midodrine not in the best interest of the patient based on medical necessity? .....  Yes  No

28. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as midodrine and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No

**Please continue to the next page.**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
<p><b>For renewal requests:</b></p> <p>29. Has the patient had clinical benefit with the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>For neurogenic orthostatic hypotension (nOH) renewal requests:</b></p> <p>30. Has the patient had improvement in severity from baseline symptoms (prior to therapy with the requested agent) of dizziness, lightheadedness, feeling faint, or feeling like the patient may black out? <b>Please note, medical records including chart notes are required.</b>..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>31. Has the patient had an increase in systolic blood pressure from baseline (prior to therapy with the requested agent) of at least 10 mmHg upon standing from a supine (laying face up) position?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p><b>Please fax or mail this form to:</b>  Prime Therapeutics LLC  Clinical Review Department  2900 Ames Crossing Road Suite 200  Eagan, MN 55121</p> <p><b>TOLL FREE</b></p>		<p><b>CONFIDENTIALITY NOTICE:</b> This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.</p>	
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