

Northera (droxidopa) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

				ORGENT		
MEMBER INFORMATION						
LAST NAME:		FIRST NAME:				
PHONE NUMBER:		DATE OF BIRTH:				
STREET ADDRESS:						
CITY:		STATE: ZIP CODE:				
PATIENT INSURANCE ID NUMBER:						
MALE FEMALE HEIGHT (IN/CM): WEIGHT (LB/KG): ALLERGIES: FYOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF						
PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):						
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:						
PRESCRIBER INFORMATION						
LAST NAME:		FIRST NAME:				
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:				
NPI NUMBER:		DEA NUMBER:				
PHONE NUMBER:		FAX NUMBER:				
STREET ADDRESS:						
CITY:		STATE: ZIP CODE:				
REQUESTOR (if different than prescriber):		OFFICE CONTACT PERSON:				
MEDICATION OR MEDICAL DISPENSING INFORMATION						
MEDICATION NAME:						
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILL	S:	QUANTITY:		
NEW THERAPY	RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:				
DURATION OF THERAPY (SPE	CIFIC DATES):					

Continued on next page.



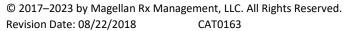


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MEMBER'S LAST NAME:	E MEMBER'S FIRST NAME:			
1. HAS THE PATIENT TRIED ANY OTHE	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:		
2. LIST DIAGNOSES:		ICD-10:		
☐ Neurogenic orthostatic hypotension (NC	PH)			
□ Other diagnosis:	ICD-10:			
	: PLEASE PROVIDE ALL RELEVANT CLINIC	CAL INFORMATION TO SUPPORT A		
 □ Parkinson disease □ Non-diabetic autonomic neuropath □ Multiple system atrophy □ Dopamine-β-hydroxylase deficiency □ Pure autonomic failure □ Other: □ Has the patient demonstrated a decrestanding for ≥ 3 minutes?* 	ease of greater than or equal to 20mm I	ng in systolic blood pressure upon		
T	ease of greater than or equal to 10mm has a submit chart documentated a large submit chart documentated a la	•		
Has the patient previously had a trial				
Please submit dates of trial.	ckings for their neurogenic orthostatic oses, symptoms, medications tried or fa	hypotension (NOH)? Yes No ailed, and/or any other information the		
information is received. ATTESTATION: I attest the informatio the Health Plan, insurer, Medical Grou	re covered on all plans. This request may n provided is true and accurate to the be p or its designees may perform a routine curacy of the information reported on th	est of my knowledge. I understand that e audit and request the medical		
Prescriber Signature or Electronic I.D.	Verification:	Date:		











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FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program

Attn: CP – 4201 P.O. Box 64811 St. Paul, MN 55164-0811

