Prior Authorization Request Form for
droxidopa **(Northera)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Does the patient have a documented diagnosis of symptomatic Neurogenic Orthostatic Hypotension (NOH)?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Is the patient's NOH due to primary autonomic failure [such as Parkinson's disease (PD), multiple system atrophy (MSA), and pure autonomic failure (PAF)], dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Is the patient 18 years of age or older?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Has the patient tried two other medications (such as fludrocortisone, pyridostigmine, or midodrine) and failed to respond to therapy?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Has the patient initiated non-pharmacological measures including but not limited to elevation of the head of the bed, orthostatic compression garments, increased salt intake, and appropriate physical training?	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved

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6. Is the requested medication being prescribed by or in consultation with a cardiologist or a neurologist?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.**
Please sign and date:

_____ _____
Prescriber Signature Date

[29 January 2020]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: