AvMed

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 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: droxidopa (Northera®)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- **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**

(Continued on next page)

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.

***Approved by Pharmacy and Therapeutics Committee**: ~~9/18/2014;~~ 1/19/2017
REVISED/UPDATED/REFORMATTED: ~~12/19/2014; 5/22/2015; 12/28/2015; 12/19/2016,~~ 1/1917; ~~3/28/2017; 8/15/2017;6/19/2019;~~ **10/27/2023**;