

## Northera® – Prior Authorization Request

Send completed form to: Case Review Unit CVS/caremark Specialty Programs Fax: 866-249-6155

CVS/caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS/caremark toll-free at 866-249-6155.** If you have questions regarding the prior authorization, please contact CVS/caremark at **866-814-5506**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect 800-237-2767.

<b>Patient Name:</b>	<b>Date:</b>
<b>Patient's ID:</b>	<b>Patient's Date of Birth:</b>
<b>Physician's Name:</b>	
<b>Specialty:</b>	<b>NPI#:</b>
<b>Physician Office Telephone:</b>	<b>Physician Office Fax:</b>

**Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia and/or evidence-based practice guidelines.**

1. What drug is being prescribed?  Northera®  Other \_\_\_\_\_
2. What is the patient's diagnosis?  
 Neurogenic orthostatic hypotension  
 Other \_\_\_\_\_
3. What is the ICD code? \_\_\_\_\_
4. What is the patient's age? \_\_\_\_\_ years
5. Has the patient received at least a 28-day supply of Northera® in a paid claim through a pharmacy or medical benefit?  
 Yes, provide start date and previous approval number: \_\_\_\_\_  No *If no, skip to question 8.*
6. Has the patient experienced a sustained decrease in dizziness since the initiation of therapy?  Yes  No
7. Has the patient experienced an increase in systolic blood pressure (SBP) within 3 minutes of standing since the initiation of therapy? *If yes, skip to question 10*  Yes  No
8. Does the patient have a persistent, consistent decrease in systolic blood pressure (SBP) of greater than or equal to 20 mmHg within 3 minutes of standing, demonstrated by serial blood pressure measurements?  Yes  No  
**Action Required: If yes, attach documentation of serial blood pressure measurements and skip to question 10.**
9. Does the patient have a persistent, consistent decrease in diastolic blood pressure (DBP) greater than or equal to 10 mmHg within 3 minutes of standing, demonstrated by serial blood pressure measurements?  Yes  No  
**Action Required: If yes, attach documentation of serial blood pressure measurements.**
10. Does the patient have primary autonomic failure due to Parkinson's disease, multiple system atrophy, or pure autonomic failure?  Yes  No  
**Action Required: If yes, attach chart notes supporting the clinical diagnosis and skip to question 13.**
11. Does the patient have dopamine beta hydroxylase deficiency?  Yes  No  
**Action Required: If yes, attach chart notes supporting the clinical diagnosis and skip to question 13.**
12. Does patient have non-diabetic autonomic neuropathy?  Yes  No  
**Action Required: If yes, attach chart notes supporting the clinical diagnosis.**
13. Will the patient be monitored for supine hypertension prior to and during treatment?  Yes  No

***I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS/caremark or the benefit plan sponsor.***

**X** \_\_\_\_\_  
**Prescriber or Authorized Signature** **Date: (mm/dd/yy)**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Northera SGM – 1/2015

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