PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Northera

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Does the patient have symptomatic neurogenic orthostatic hypotension (NOH)?

☐ Yes ☐ No

Q2. Please provide ICD code(s) for diagnosis.

Q3. Specify the prescriber's specialty

☐ Cardiologist ☐ Neurologist ☐ Other

Q4. Is the patient a new start to Northera?

☐ Yes ☐ No - please specify start date

Q5. Is the patient's NOH caused by any of the following? Please specify all that apply.

☐ Primary autonomic failure (i.e. Parkinson's disease, multiple system atrophy, or pure autonomic failure)
☐ Dopamine beta-hydroxylase deficiency
☐ Non-diabetic autonomic neuropathy
☐ Other (please specify)

Q6. Does the patient have failure of an adequate trial of, clinically significant intolerance or contraindication to the

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following? Please select all that apply

- ☐ Fludrocortisone
- ☐ Midodrine
- ☐ Other (please specify)

Q7. For continuation, does the patient have documented response to therapy with any of the following? Please select all that apply.

- ☐ Clinically significant decrease in dizziness
- ☐ Clinically significant decrease in lightheadedness
- ☐ Clinically significant decrease in fainting
- ☐ Other (please specify)

Q8. For continuation, has the patient experienced supine hypertension during treatment?

☐ Yes ☐ No

Q9. Additional Comments

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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