

## 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.** 

Deff of North		Prescriber Name:	
Patient Name:		Supervising Physicia	in:
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 h		for this patient that m	ay support approval. Please answer the
Q1. Does the patient have symptomatic	c neurogenic orthost	atic hypotension (NC	H)?
☐ Yes		☐ No	
Q2. Please provide ICD code(s) for dia	gnosis.		
Q3. Specify the prescriber's specialty			
☐ Cardiologist	□ Neurologist		☐ Other
Q4. Is the patient a new start to Northe	ra?		
☐ Yes	☐ No - please specify start date		
Q5. Is the patient's NOH caused by any	y of the following? Pl	ease specify all that	apply.
☐ Primary autonomic failure (i.e. Pa	arkinson's disease, r	nultiple system atrop	hy, or pure autonomic failure)
Dopamine beta-hydroxylase defi	ciency		
☐ Non-diabetic autonomic neuropa	thy		
☐ Other (please specify)			
Q6. Does the patient have failure of an	adequate trial of, cli	nically significant into	elerance 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 reall that apply.	esponse to therapy with any of the following? Please select
☐ 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 h	ypertension during treatment?
☐ Yes	□ No
Q9. Additional Comments	
Prescriber Signature	Date
□ Expedited/Urgent - By checking this box and signing abov	and a self-field and being the self-and and and are found to

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.

seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function



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