CVS caremark™ {{PANUMCODE}}

Northera [droxidopa]

Prior Authorization Request

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 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the prescribed product? ❑ Northera ❑ droxidopa
2. What is the diagnosis?
   ❑ Neurogenic orthostatic hypotension
   ❑ Other _____
3. What is the ICD-10 code? _____
4. The preferred product for your patient's health plan is generic midodrine. Can the patient's treatment be switched to the preferred product? ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   ❑ Yes - generic midodrine
   ❑ No - Continue request for Northera and/or droxidopa
5. Does the patient have a documented inadequate response to treatment with the preferred product (generic midodrine)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) and skip to #7.*** ❑ Yes ❑ No
6. Does the patient have a documented intolerable adverse event with the preferred product (generic midodrine)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No
7. Does the patient have primary autonomic failure due to Parkinson's disease, multiple system atrophy, or pure autonomic failure? *If Yes, skip to #10* ❑ Yes ❑ No
8. Does the patient have dopamine beta hydroxylase deficiency? *If Yes, skip to #10* ❑ Yes ❑ No
9. Does the patient have non-diabetic autonomic neuropathy? ❑ Yes ❑ No
10. Is this request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #12*
11. Has the patient experienced a sustained decrease in dizziness since the initiation of therapy?
    ❑ Yes ❑ No *No further questions.*

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization. Fax: 1-866-249-6155

12. 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 or head-up tilt test? ***ACTION REQUIRED: If Yes, attach blood pressure readings or documentation of head-up tilt* test *and no further questions.*** ❑ Yes ❑ No

13. 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 or head-up tilt test? ***ACTION REQUIRED: If Yes, attach blood pressure readings or documentation of a head-up tilt test.*** ❑ 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)**

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization. Fax: 1-866-249-6155