Prescriber Criteria Form Northera 2025 PA Fax 1142-A v1 010125.docx Northera (droxidopa) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Northera (droxidopa).

Drug Name: Northera (droxidopa)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of neurogenic orthostatic hypotension (nOH)? [If no, then no further questions.]	Yes ◯	No ◯
2	Is the patient currently receiving the requested drug? [If no, then skip to question 4.]	Yes ◯	No ◯
3	Has the patient experienced a sustained reduction in symptoms of neurogenic orthostatic hypotension (i.e., decrease in dizziness, lightheadedness, or feeling faint) since the initiation of therapy? [If yes, then skip to question 6.] [If no, then no further questions.]	Yes ◯	No ◯
4	Does the patient have a persistent, consistent decrease in systolic blood pressure of at least 20 millimeters of Mercury (mmHg) within 3 minutes of standing or head-up tilt test? [If yes, then skip to question 6.]	Yes ◯	No ◯
5	Does the patient have a persistent, consistent decrease in diastolic blood pressure of at least 10 millimeters of Mercury (mmHg) within 3 minutes of standing or head-up tilt test? [If no, then no further questions.]	Yes ◯	No ◯
6	Does the patient have primary autonomic failure due to Parkinson's disease, multiple system atrophy, or pure autonomic failure? [If yes, then no further questions.]	Yes ◯	No ◯

7	Does the patient have dopamine beta-hydroxylase deficiency? [If yes, then no further questions.]	Yes ◯	No ◯
8	Does the patient have non-diabetic autonomic neuropathy?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____