US Family Health Plan
Prior Authorization Request Form for
Droxidopa **(Northera)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Medical documentation may be required. Failure to provide could result in denial.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:	______________	Physician Name:	______________
Address:	______________	Address:	______________
	______________		______________
Sponsor ID #:	______________	Phone #:	______________
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

Question	Yes	No
1. Does the patient have a documented diagnosis of symptomatic Neurogenic Orthostatic Hypotension (NOH)?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Is the patient's NOH due to primary autonomic failure [such as Parkinson's disease (PD), multiple system atrophy (MSA), and pure autonomic failure (PAF)], dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Is the patient 18 years of age or older?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Has the patient tried two other medications (such as fludrocortisone, pyridostigmine, or midodrine) and failed to respond to therapy?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Has the patient initiated non-pharmacological measures including but not limited to elevation of the head of the bed, orthostatic compression garments, increased salt intake, and appropriate physical training?	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved

6. Is the requested medication being prescribed by or in consultation with a cardiologist or a neurologist?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _______________ Date _______________