



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit go.covermymeds.com/OptumRx to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Northera[®] Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below:					
<input type="checkbox"/> Neurogenic orthostatic hypotension (NOH)					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical Information:					
Does the patient have symptomatic NOH? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Select if NOH is caused by the following conditions:					
<input type="checkbox"/> Primary autonomic failure (e.g., Parkinson's disease, multiple system atrophy, pure autonomic failure)					
<input type="checkbox"/> Dopamine beta-hydroxylase deficiency					
<input type="checkbox"/> Non-diabetic autonomic neuropathy					
Select if Northera is prescribed by or in consultation with one of the following specialists:					
<input type="checkbox"/> Cardiologist					
<input type="checkbox"/> Neurologist					
<input type="checkbox"/> Nephrologist					
Has an attempt been made to manage NOH through at least one non-pharmacologic intervention (e.g., use of compression stockings/abdominal binder, increasing salt/fluid intake, patient participates in regular exercise, discontinue or reduce hypotensive or antihypertensive medications)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the patient had a trial and failure, contraindication, or intolerance to fludrocortisone acetate or midodrine? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Reauthorization:					
Is there documentation the patient has had a positive clinical response to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note:

This request may be denied unless all required information is received.

For urgent or expedited requests please call 1-800-711-4555.

This form may be used for non-urgent requests and faxed to 1-800-527-0531.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Northera_Comm_2018Feb-W