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)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Neurogenic orthostatic hypotension (NOH)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Does the patient have symptomatic NOH? ❑ **Yes** ❑ **No**

Select if NOH is caused by the following conditions:

- ❑ Primary autonomic failure (e.g., Parkinson's disease, multiple system atrophy, pure autonomic failure)
- ❑ Dopamine beta-hydroxylase deficiency
- ❑ Non-diabetic autonomic neuropathy

Select if Northera is prescribed by or in consultation with one of the following specialists:

- ❑ Cardiologist
- ❑ Neurologist
- ❑ 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)? ❑ **Yes** ❑ **No**

Has the patient had a trial and failure, contraindication, or intolerance to fludrocortisone acetate or midodrine? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had a positive clinical response to therapy? ❑ **Yes** ❑ **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.