Prescription & Enrollment Form

Droxidopa Generic for Northera®

accredo®

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient's first name _____

Last name _____ Middle initial _____

Date of birth _____ ❑ Male ❑ Female Last 4 digits of SSN _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail _____

❑ OK to leave message with alternate caregiver/contact

Patient's primary language: ❑ English ❑ Other If other, please specify _____

Please attach copies of front and back of the patient's medical and prescription insurance cards.

Insurance company _____

Phone _____

Insured's name _____

Insured's employer _____

Relationship to patient _____

Identification # _____

Policy/group # _____

Prescription card: ❑ Yes ❑ No If yes, carrier _____

Policy # _____ Group # _____

Is patient eligible for Medicare? ❑ Yes ❑ No

Does patient have a secondary insurance? ❑ Yes ❑ No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Prescriber's first name _____ Last name _____

Prescriber's title _____

If NP or PA, under direction of Dr. _____

Office contact and title _____

Office contact phone _____ Office contact e-mail _____

Office/clinic/institution name _____

Clinic/hospital affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____

NPI # _____ License # _____

Deliver product to: ❑ Office ❑ Patient's home ❑ Clinic

Clinic location _____

3 CLINICAL INFORMATION

Diagnosis: Please identify both: 1) the primary diagnosis being treated with Droxidopa and 2) the symptomatic condition being treated with Droxidopa.

1) Primary diagnosis:

❑ G20 Parkinson's Disease ❑ G90.9 Disorder of the autonomic nervous system, unspecified

❑ G99.0 Autonomic neuropathy in diseases classified elsewhere

❑ G90.3 Multi-system degeneration of the autonomic nervous system

❑ Other _____

2) Symptomatic condition:

❑ Neurogenic orthostatic hypotension (currently no nOH-specific ICD-10 exists)

❑ I95.1 Orthostatic hypotension ❑ I95.89 Other hypotension ❑ R55 Syncope and collapse

❑ R42 Dizziness and giddiness ❑ Other _____

Check all that apply:

❑ Failure or inadequate response to nonpharmacologic therapy.

Therapy Name _____

❑ Failure ❑ inadequate response ❑ contraindication or ❑ intolerance to **fludrocortisone**

❑ Failure ❑ inadequate response ❑ contraindication or ❑ intolerance to **midodrine**

Patient weight (kg) _____ Date of weight _____

❑ NKDA Drug and non-drug allergies _____

Concurrent meds _____

4 PRESCRIBING INFORMATION

STARTER DOSE

Medication	Strength/Formulation	Directions	Quantity/Refills
❑ Droxidopa	100mg capsules	Take 100mg by mouth three times a day then increase dose by 100mg per dose every _____ days. Take last dose at least 3 hours before bedtime.	Dispense: ❑ 30-day supply ❑ Other _____ Refills: 0
❑ Northera® (droxidopa)	100mg capsules	Take 100mg by mouth three times a day then increase dose by 100mg per dose every _____ days. Take last dose at least 3 hours before bedtime.	Dispense: ❑ 30-day supply ❑ Other _____ Refills: 0

• Titrate to a symptomatic response. Maximum daily dose required will vary by individual. • Monitor supine blood pressure prior to initiating Northera and after increasing the dose.
• Max dose is 600 mg TID.

MAINTENANCE DOSE (physician check box of requested dose)

Medication	Strength/Formulation	Directions	Quantity/Refills
❑ Droxidopa	❑ 100mg ❑ 200mg ❑ 300mg ❑ Other dose than listed above: _____ morning, _____ noon and _____ afternoon	Take _____ by mouth three times a day. Take last dose at least 3 hours before bedtime.	Dispense: ❑ 30-day supply ❑ 90-day supply ❑ Other _____ Refills: _____
❑ Northera® (droxidopa)	❑ 100mg ❑ 200mg ❑ 300mg ❑ Other dose than listed above: _____ morning, _____ noon and _____ afternoon	Take _____ by mouth three times a day. Take last dose at least 3 hours before bedtime.	Dispense: ❑ 30-day supply ❑ 90-day supply ❑ Other _____ Refills: _____

By signing below, I certify that the above therapy is medically necessary. I also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited. **Prescriber's signature (sign below)** **(Physician attests this is his/her legal signature. NO STAMPS)**

PHYSICIAN SIGNATURE REQUIRED

_____ _____ _____ _____

Date Dispense as written Date Substitution allowed

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Please fax completed form to 888.302.1028. To reach your team, call toll-free 844.412.4764.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.