Please fax both pages of completed form to your team at 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.

Prescription & Enrollment Form

Droxidopa Generic for Northera®

accredo®

Four simple steps to submit your referral.

1 Patient Information

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

❑ New patient ❑ Current patient

Patient's first name _____ Last name _____ Middle initial _____

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

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail address _____

❑ OK to leave message with alternate caregiver/contact

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

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 address _____

Office contact and title _____

Office contact phone number _____ Office contact e-mail _____

Office/Infusion clinic name _____ Office/Infusion clinic 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 ❑ Known drug allergies _____

Concurrent meds _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

STARTER DOSE			
Medication	**Dose**	**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	**Dose**	**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: _____

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

Prescriber's signature (sign below) **(Physician attests this is his/her legal signature. NO STAMPS)** PHYSICIAN SIGNATURE REQUIRED

SIGN HERE

_____ _____ _____ _____

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.

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