

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
<input type="checkbox"/> 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: <input type="checkbox"/> 30-day supply <input type="checkbox"/> Other _____ Refills: 0
<input type="checkbox"/> 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: <input type="checkbox"/> 30-day supply <input type="checkbox"/> 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
<input type="checkbox"/> Droxidopa	<input type="checkbox"/> 100mg <input type="checkbox"/> 200mg <input type="checkbox"/> 300mg <input type="checkbox"/> 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: <input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply <input type="checkbox"/> Other _____ Refills: _____
<input type="checkbox"/> Northera® (droxidopa)	<input type="checkbox"/> 100mg <input type="checkbox"/> 200mg <input type="checkbox"/> 300mg <input type="checkbox"/> 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: <input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply <input type="checkbox"/> 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.