Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Droxidopa - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the request for droxidopa for reauthorization? If YES, go to 2. If NO, go to 3.

☐ Yes ☐ No

Q2. Has the patient had a positive clinical response to droxidopa with improvement in symptoms?

☐ Yes ☐ No

Q3. Does the patient have a documented diagnosis of neurogenic orthostatic hypotension (nOH) caused by one of the following: (1) primary autonomic failure (e.g. Parkinson's disease, multiple system atrophy, and pure autonomic failure), (2) dopamine beta-hydroxylase deficiency, or (3) non-diabetic autonomic neuropathy?

☐ Yes ☐ No

Q4. Is the requested drug being prescribed by or in consultation with a cardiologist or a neurologist?

☐ Yes ☐ No

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Member Name:	**Prescriber Name:**

Q5. Is there documentation of an inadequate response, intolerance, or contraindication to fludrocortisone or midodrine?

☐ Yes ☐ No

Q6. Requested Duration:

☐ 3 Months ☐ Other:

Q7. Additional Information:

_____ _____

Prescriber Signature Date

v2025