GETTING YOUR PATIENT STARTED WITH NORTHERA® (droxidopa)

Northera® (droxidopa) capsules 100 mg • 200 mg • 300 mg

This form can also be completed online at NORTHERAhcp.com

If prescribing through the Northera Support Center (NSC), complete this form in its entirety and fax pages 2–4 to 844-601-0102.

Every effort is made to limit the number of calls to your office. Please ensure that:

- ☐ All required **(red and underlined)** fields are complete
- ☐ Patient (or authorized representative) has signed the HIPAA release on page 2
- ☐ Initial NORTHERA Prescription Information, including dosing schedule, is completed
- ☐ Prescriber's signature appears on the bottom of page 4

The provider **must sign the prescription form** before faxing the completed form. Prescriber **must write "Brand necessary" below signature if choosing "Dispense as written."** In addition, the patient or caregiver should sign the HIPAA release to ensure that the NSC can contact him or her directly if more information is needed.

Upon receipt of your patient's completed forms, the NSC will help confirm insurance coverage information.

The NSC may contact your office via phone or fax to:

- Obtain any information that was left off the treatment form
- Clarify information provided on the Northera enrollment form

The StarterRx Program provides a one-time 30-day supply shipment of NORTHERA to eligible commercial patients who qualify.

Eligibility requirements:

- New patients age 17 and older with a valid NORTHERA prescription
- Commercially insured patients
- Diagnosis consistent with labeling

If the patient doesn't meet eligibility criteria for the StarterRx Program, the prescription will be filled by the specialty pharmacy. Complete Terms and Conditions for the StarterRx Program are available at NORTHERAhcp.com.

Advise your patient that the NSC will be calling to help ensure delivery of his or her NORTHERA prescription.

- The NSC requires verbal confirmation of the delivery address from your patient prior to mailing his or her medication

After prescribing NORTHERA, you may need to initiate a prior authorization (PA).

Use CoverMyMeds to streamline the PA approval and appeals processes for NORTHERA[1,2]

CoverMyMeds electronically connects providers, pharmacists, and health plans, helping patients to more quickly get the medication they need.[2]

For additional information: Call toll free **1-866-452-5017** or visit **CoverMyMeds.com**

covermymeds®

References: 1. Data on file. Deerfield, IL: Lundbeck. **2.** CoverMyMeds. ePA solutions to streamline the PA process for all stakeholders. https://www.covermymeds.com/main/. Accessed May 13, 2020.

Please see accompanying Important Safety Information, including Boxed Warning for supine hypertension, on page 5. For more information, please see the accompanying NORTHERA full Prescribing Information, or go to NORTHERAhcp.com.

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Fax pages 2–4 to the NSC at 844-601-0102

Red and underlined fields are required

NORTHERA Treatment Form

HIPAA RELEASE

Patient Authorization for Use and Disclosure of Personal Health Information

I authorize my healthcare providers (including pharmacy providers) and health plans to disclose my personal health information related to this prescription form or my use or potential use of NORTHERA, including my personal contact information on this form (collectively, my "Information"), to the patient support program called the NORTHERA Support Center (the "Program") so that the Program may use and disclose the Information in order to: (1) establish my benefit eligibility; (2) communicate with my healthcare providers and health plans about my benefit and coverage status and my medical care; (3) provide support services, including facilitating the provision of NORTHERA to me, as well as any information or materials related to such services or Lundbeck products, including promotional or educational communications; (4) evaluate the effectiveness of NORTHERA support programs; (5) report safety information, including in communications with the US Food and Drug Administration and other government authorities; (6) contact me regarding this prescription form or my use or potential use of NORTHERA and provide me with related patient support communications, including through messages left for me that disclose that I take or may take NORTHERA; and (7) allow Lundbeck to analyze the usage patterns and the effectiveness of Lundbeck products, services, and programs and help develop new products, services, and programs, and for other Lundbeck general business and administrative purposes.

I understand that my pharmacy provider(s) may receive remuneration in exchange for the provision of my Information as authorized above, and that once my Information has been disclosed to the Program, federal privacy law may no longer restrict its use or disclosure and that it may be redisclosed to others. I also understand, however, that the Program plans to use and disclose my Information only for the purposes described above or as required by law.

I understand that if I refuse to sign this Authorization, that will not affect my right to treatment or payment benefits for health care. I also understand that if I sign, I may later withdraw this Authorization by sending written notice of my withdrawal from the Program to the NORTHERA Support Center Coordinating Center at PO Box 220267, Charlotte, NC 28222, and that such withdrawal will not affect any uses and disclosures of my Information prior to the Program's receipt of the notice. I am entitled to a copy of this signed Authorization, which expires 10 years from the date it is signed by me or such timeframe as allowed by law.

PATIENT HIPAA

PATIENT/GUARDIAN SIGNATURE:	PATIENT/GUARDIAN NAME (PLEASE PRINT):	DATE:

RELATIONSHIP TO PATIENT: ☐ Self ☐ Spouse ☐ Other[a] _____

AUTHORIZED REPRESENTATIVE CONSENT (OPTIONAL)

I further authorize the NORTHERA Support Center to discuss my treatment with the following authorized representative(s).

AUTHORIZED REPRESENTATIVE (1) NAME (PLEASE PRINT):

RELATIONSHIP TO PATIENT: ☐ Spouse ☐ Child ☐ Other: _____

AUTHORIZED REPRESENTATIVE (2) NAME (PLEASE PRINT):

RELATIONSHIP TO PATIENT: ☐ Spouse ☐ Child ☐ Other: _____

[a]Please note documentation proving Power of Attorney may be required.

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NORTHERA Treatment Form

PATIENTS MUST SIGN THE HIPAA RELEASE ON PAGE 1 IN ORDER TO RECEIVE ALL SUPPORT SERVICES OFFERED BY THE NSC.

1 Patient Information

PATIENT FIRST, LAST NAME:		DOB (MM/DD/YYYY):	GENDER: ☐ M ☐ F
MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:
PRIMARY PHONE: ( ) ☐ Home ☐ Cell ☐ Work	☐ CHECK HERE IF PATIENT IS IN THE HOSPITAL. DISCHARGE DATE: _____		
SECONDARY PHONE: ( ) ☐ Home ☐ Cell ☐ Work	EMAIL:		
PREFERRED CONTACT TIME: ☐ Morning ☐ Afternoon ☐ Evening	☐ I AUTHORIZE THE NSC TO DISCUSS MY TREATMENT WITH:		
PRIMARY LANGUAGE:	_____		

2 Patient Insurance Attach copies of both sides of patient's pharmacy benefit card(s) OR complete the following

PRIMARY INSURANCE:	ID NUMBER:
PHONE: ( )	CARDHOLDER NAME:
PLAN NUMBER:	GROUP NUMBER:
RELATIONSHIP TO CARDHOLDER: ☐ Self ☐ Spouse ☐ Child ☐ Other:	
☐ CHECK IF NO COVERAGE	

3 Clinical Information

Has a clinical evaluation of the patient's current medications been performed to evaluate for any medications that may precipitate hypotension?	☐ Yes ☐ No

Patient concomitant medications: _____

☐ Drug allergies: _____

☐ No known drug allergies (NKDA)

Will the patient be monitored for supine hypertension prior to and during treatment?	☐ Yes ☐ No
Does the patient have any contraindications to the use of NORTHERA (eg, hypersensitivity to NORTHERA or any of its components)?	☐ Yes ☐ No

WHAT IS THE PATIENT'S PRIMARY DIAGNOSIS? (CHECK ONE OF THE FOLLOWING):

- ☐ G20 Parkinson's disease (PD)
- ☐ G23.2 Striatonigral degeneration
- ☐ G90.3 Multi-system degeneration of the autonomic nervous system
- ☐ G90.9 Disorder of the autonomic nervous system, unspecified*
- ☐ G99.0 Autonomic neuropathy in diseases classified elsewhere*

*NORTHERA is not indicated for the treatment of symptomatic neurogenic orthostatic hypotension (nOH) caused by diabetic autonomic neuropathy.

- ☐ Dopamine beta-hydroxylase (DBH) deficiency
  Attach chart notes supporting the clinical diagnosis.
- ☐ Non-diabetic autonomic neuropathy (NDAN)
  Attach chart notes supporting the clinical diagnosis.
- ☐ Other (Include ICD code): _____
  Attach chart notes supporting the clinical diagnosis.

SYMPTOMATIC CONDITION(S) (CHECK ONE OR ALL THAT APPLY):

- ☐ Neurogenic orthostatic hypotension (nOH)
- ☐ R42 Dizziness and giddiness
- ☐ I95.1 Orthostatic hypotension
- ☐ I95.89 Other hypotension
- ☐ R55 Syncope and collapse
- ☐ Other (Include ICD code): _____

Has the patient tried and failed or is intolerant to midodrine?	☐ Yes ☐ No
Has the patient tried and failed or is intolerant to fludrocortisone?	☐ Yes ☐ No

Has the patient tried any of the following non-pharmacologic interventions? (Check all that apply):

- ☐ Discontinuation of drugs, which can cause orthostatic hypotension (eg, diuretics, antihypertensive medications [primarily sympathetic blockers], anti-anginal drugs [nitrates], alpha-adrenergic antagonists, and antidepressants)
- ☐ Increased salt and water intake, if appropriate
- ☐ Raising the head of the bed 10 to 20 degrees
- ☐ Compression stockings
- ☐ Physical maneuvers to improve venous return
- ☐ Avoiding precipitating factors (eg, overexertion in hot weather, arising too quickly from supine to sitting or standing)
- ☐ Other: _____

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Red and underlined fields are required

NORTHERA Treatment Form

4 Prescriber Information

PRESCRIBER NAME:			
SPECIALTY: ☐ Neurologist ☐ Cardiologist ☐ Nephrologist ☐ Other: _____		**NPI #:**	**STATE ID:**
PRACTICE/FACILITY NAME:		**OFFICE CONTACT NAME:**	
MAILING ADDRESS:		**OFFICE CONTACT PHONE:** ( )	
CITY:	***STATE:** **ZIP CODE:**	**OFFICE CONTACT FAX:** ( )	
OFFICE/PRESCRIBER EMAIL:			

5 Initial NORTHERA Prescription Information

PATIENT FIRST, LAST NAME:				**DOB (MM/DD/YYYY):**
MAILING ADDRESS:	**CITY:**	**STATE:**	**ZIP CODE:**	**PHONE:** ( )

CHOOSE ONLY ONE OPTION BELOW.

☐ A — STANDARD 24-HR SCHEDULE

NORTHERA 24-HOUR TITRATION SCHEDULE

Dispense: NORTHERA 100 mg capsules (30-day supply) Sig: To be filled by the pharmacy to reflect indicated titration schedule. Qty = 495 Refills = 0

Administer 3 times daily: when you get up in the morning, at midday, and in late afternoon (at least 3 hours before bed)

Day 1	Day 2	Day 3	Day 4	Day 5	Day 6-30[a]
100 mg	200 mg	300 mg	400 mg	500 mg	600 mg

Additional instructions:

☐ B — STANDARD 48-HR SCHEDULE

NORTHERA 48-HOUR TITRATION SCHEDULE

Dispense: NORTHERA 100 mg capsules (30-day supply) Sig: To be filled by the pharmacy to reflect indicated titration schedule. Qty = 450 Refills = 0

Administer 3 times daily: when you get up in the morning, at midday, and in late afternoon (at least 3 hours before bed)

Days 1 and 2	Days 3 and 4	Days 5 and 6	Days 7 and 8	Days 9 and 10	Days 11-30[a]
100 mg	200 mg	300 mg	400 mg	500 mg	600 mg

Additional instructions:

☐ C — CUSTOM SCHEDULE

NORTHERA CUSTOM TITRATION SCHEDULE

Dispense: NORTHERA 100 mg capsules (Qty sufficient for 30-day supply) Sig: To be filled by the pharmacy to reflect indicated titration schedule. Refills = 0

Day(s) ___-___	Day(s) ___-___	Day(s) ___-___	Day(s) ___-___	Day(s) ___-___	Day(s) ___-___	Day(s) ___-30[a]
100 mg _____ times daily	_____ mg _____ times daily	_____ mg _____ times daily	_____ mg _____ times daily	_____ mg _____ times daily	_____ mg _____ times daily	_____ mg _____ times daily

Additional instructions:

☐ D — CUSTOM SCHEDULE

NORTHERA FIXED SCHEDULE

The quantity will be calculated at the pharmacy based upon indicated schedule for a 30-day supply. Refills = 0

Dispense: NORTHERA ☐ 100 mg capsules ☐ 200 mg capsules ☐ 300 mg capsules Sig: Take _____ mg _____ time(s) daily

Additional instructions: Please dispense a 30-day supply unless otherwise noted

[a]**Continued effectiveness of NORTHERA should be assessed periodically.**

Prescriber Certification and Authorization: I certify that, to the full extent required by applicable law, I have obtained written permission from my patient named above (or from the patient's legal representative) to release to the patient support program, the NORTHERA Support Center ("the Program"), the patient's personal health information, both as provided on this form and such other personal health information as the Program may need (1) to perform a preliminary verification of the patient's insurance coverage for NORTHERA, (2) to assess the patient's eligibility for participation in the Program, (3) to enroll the patient in the Program, (4) to provide reimbursement support and other services to the patient in connection with the patient's prescription(s) on this form, and (5) for the other purposes identified on the Patient Authorization for Use and Disclosure of Personal Health Information. I authorize and appoint the Program to convey on my behalf the prescription(s) I signed for the patient and the other information included on this form to the dispensing pharmacy chosen by or for the patient. I agree that the Program may contact me, including without limitation via email, fax, and telephone, to seek additional information relating to the Program, NORTHERA, or the prescription(s) contained on this form.

I understand that any NORTHERA provided at no charge to the patient is provided on a complimentary basis. I will not submit or cause to be submitted any claims for payment or reimbursement for such products to any third-party payor, including a federal health care program. If I am or become in possession of such product, I will not resell or attempt to resell the product.

Write "Brand necessary" along with the signature for "Dispense as written."

PRESCRIBER SIGNATURE (SIGN BELOW)

DISPENSE AS WRITTEN/WRITE BRAND NECESSARY	**DATE**	**PRODUCT SUBSTITUTION PERMITTED**	**DATE**

SIGNATURE STAMPS NOT ACCEPTABLE

*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. If choosing "Dispense as Written/Brand Necessary," additional information may be needed from the prescriber.

DRX-B-100370v3

Please see accompanying Important Safety Information, including Boxed Warning for supine hypertension, on page 5. For more information, please see the accompanying NORTHERA full Prescribing Information, or go to NORTHERAhcp.com.

Questions? Call the NSC toll-free at 844-601-0101