GETTING YOUR PATIENT STARTED WITH NORTHERA™ (droxidopa)

NORTHERA is only available via Specialty Pharmacy and by using the enclosed NORTHERA Treatment and Prescription Forms. The NORTHERA Support Center works with you and your staff to ensure that your patients have access to treatment with NORTHERA.

Complete the NORTHERA Treatment Form and the NORTHERA Prescription Form in their entirety and fax both to 844-601-0102.

In order to expedite your patient's prescription, please ensure that:

- All required **(red)** fields are complete
- Patient (or caregiver) has signed STEP 1 of the NORTHERA Treatment Form
- Prescriber has signed STEP 3 of the NORTHERA Treatment Form
- Titration details on the NORTHERA Prescription Form are complete
- Prescriber's printed name and signature appear on STEP 5 of the NORTHERA Prescription Form

Upon receipt of your patient's completed forms, the NORTHERA Support Center will begin a benefits investigation. They may contact your office via phone or fax for additional information necessary to expedite your patient's prescription.

Reasons the NORTHERA Support Center may contact your office include:

- Missing information from the NORTHERA Treatment Form and/or Prescription Form
- Patient insurance requiring prior authorization for coverage

Every effort is made to limit the number of calls to your office.

Please advise your patient that the NORTHERA Support Center will be calling them to help ensure prompt delivery of their NORTHERA prescription, answer their questions, and provide ongoing support.

- Please note the NORTHERA Support Center requires verbal confirmation of the delivery address from your patient before sending the prescription
- These calls may appear as "Unknown Caller" on your patient's caller ID

Upon completion of your patient's benefits investigation, the NORTHERA Support Center will triage your patient's prescription to the appropriate Specialty Pharmacy to ensure timely refills of NORTHERA. The Specialty Pharmacy may contact your office about using alternative strengths for the refill.

DRX-B-00023a(4) 03/2015 **www.NORTHERA.com**

NORTHERA™ (droxidopa) TREATMENT FORM

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

Please complete this form in its entirety and fax to the NORTHERA Support Center at **844-601-0102**.
Questions? Call toll-free **844-601-0101**.
***Indicates required field**

Step 1: Patient Information

***PATIENT NAME:**			***DOB (DD/MM/YYYY):** / ***GENDER:** ☐ Male ☐ Female
***ADDRESS:**			***PHONE:** ( )
***CITY:**	***STATE:**	***ZIP CODE:**	ALTERNATE PHONE: ( )
EMAIL:			PREFERRED CONTACT TIME: ☐ Morning ☐ Afternoon ☐ Evening

Please read HIPAA Release statement on back.

***PATIENT/GUARDIAN SIGNATURE:**	***DATE:**
RELATIONSHIP TO PATIENT:	

Step 2: Patient Insurance

Complete the information below OR include copies of insurance cards. ☐ **Patient is uninsured**

***PRIMARY INSURANCE COMPANY:**	***PHONE:** ( )
***ID NUMBER:**	PLAN NUMBER:
CARDHOLDER NAME:	GROUP NUMBER:
RELATIONSHIP TO CARDHOLDER: ☐ Self ☐ Spouse ☐ Child ☐ Other:	
SECONDARY INSURANCE COMPANY:	PHONE: ( )
ID NUMBER:	PLAN NUMBER:
CARDHOLDER NAME:	GROUP NUMBER:

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HIPAA Release

By signing this authorization, I authorize my health plans, physicians, and pharmacy providers to disclose my personal health information, including, but not limited to, information relating to my medical condition, treatment, care management, and health insurance, as well as information provided on this form and any prescription ("Personal Health Information"), to Lundbeck LLC ("Lundbeck") and its representatives, agents, and contractors, including to Lundbeck's NORTHERA Support Center operated by The Lash Group, Inc. on behalf of Lundbeck (collectively, "the Entities") (1) for the processing of my prescriptions by the NORTHERA Support Center, my health plan, and my pharmacy providers; (2) to facilitate the provision of products, supplies or services by a third party including, but not limited to, specialty pharmacies; (3) to register me in any applicable product registration program required for my treatment; (4) to evaluate the effectiveness of NORTHERA's education; and (5) to be contacted by third parties for research purposes. I understand that my pharmacy provider(s) will disclose to Lundbeck and/or its representatives, agents, and subcontractors certain personal health information regarding the dispensing of my NORTHERA prescription and that such disclosure will result in remuneration to my pharmacy provider(s). I understand that once my Personal Health Information is disclosed under this authorization, it is no longer protected by Federal privacy laws and may be further disclosed by the Entities; however, Lundbeck agrees to protect my information and only use and disclose it for the purposes described above, or as I may further authorize in writing, or as required by law. I understand that I may refuse to sign this authorization and that treatment, payment, enrollment, or eligibility for benefits is not conditioned on my signing this authorization. I understand that I am entitled to a copy of this authorization. I understand that I may cancel this authorization at any time by mailing a letter requesting such cancellation to Lash Group, Inc., 9717 Key West Avenue, Rockville, MD 20850, but that this cancellation will not apply to any information already used or disclosed through this authorization before notice of the cancellation is received by my health plans or healthcare providers. This authorization expires ten (10) years from the date signed.

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Questions? Call toll-free **844-601-0101**.
***Indicates required field**

Step 3: Prescriber Information

***PRESCRIBER NAME:**		***NPI #:**	STATE LICENSE #:
PRACTICE/FACILITY NAME:		***PRIMARY CONTACT NAME:**	
***ADDRESS:**		***PHONE:** ( )	
***CITY:**	***STATE:** / ***ZIP CODE:**	***FAX:** ( )	
PRESCRIBER EMAIL:			

Prescriber Certification: I certify that I have obtained any legally required written permission of my patient (or the patient's legal representative) for the release of my patient's information here and such other health or personal information to the NORTHERA Support Center ("the Program") and Lundbeck LLC and/or its representatives or agents (collectively, "Lundbeck") as may be necessary for the patient's participation in the Program and for the Program and Lundbeck to use and disclose such information as necessary to provide reimbursement support and other services to me and my patient in connection with the patient's NORTHERA therapy. I authorize and appoint the Program and Lundbeck to convey on my behalf any prescription information delivered to the Program for NORTHERA to the dispensing pharmacy chosen by or for the patient. I understand that the Program and Lundbeck will use and disclose this information only in connection with the Program, including but not limited to performing a preliminary verification of my patient's insurance coverage for NORTHERA and assessing my patient's eligibility for participation in the Program and as otherwise required or permitted by law. I agree that the Program and Lundbeck may contact me for additional information relating to the Program or NORTHERA, including but not limited to via email, fax, and telephone.

***PRESCRIBER SIGNATURE:**	***DATE:**

Step 4: Clinical Information

***PATIENT NAME:**	***DOB (DD/MM/YYYY):**

Please identify both 1) the primary diagnosis being treated with NORTHERA and 2) the symptomatic condition(s) being treated with NORTHERA.

1) *PRIMARY DIAGNOSIS:

- ☐ 332 Parkinson's disease
- ☐ 337 Autonomic failure/neuropathy
- ☐ 333 Multiple system atrophy
- ☐ Other:

2) *SYMPTOMATIC CONDITION (check all that apply):

- ☐ Neurogenic orthostatic hypotension (currently no NOH-specific ICD-9 exists)
- ☐ 458.0 Orthostatic hypotension
- ☐ 458.1 Chronic hypotension
- ☐ 458.9 Hypotension unspecified
- ☐ 780.2 Syncope and collapse
- ☐ 780.4 Dizziness and giddiness
- ☐ Other:

CHECK ALL THAT APPLY:

Nonpharmacologic therapy	☐ Failure or inadequate response	Therapy description: _____		
Fludrocortisone	☐ Failure	☐ inadequate response	☐ contraindication	☐ intolerance
Midodrine	☐ Failure	☐ inadequate response	☐ contraindication	☐ intolerance

By filling out this form, your patient will be automatically enrolled in the NORTHERA Support Center Nurse Program.

- ☐ **Check here if you choose not to enroll your patient in the NORTHERA Support Center Nurse Program.**
- ☐ **Check here if you do not want your patient to learn whether they qualify for a free home blood pressure monitoring device.**

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