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 in its entirety and fax pages 1, 2, and 3 to 844-601-0102.

Every effort is made to limit the number of calls to your office. In order to expedite your patient’s prescription, please ensure that:

- All required (red) fields are complete
- Patient (or authorized representative) has signed the HIPAA release on page 1
- Titration Prescription is completed (select option A, B, or C). For option C, ensure detailed administration instructions are provided
- Prescriber’s signature appears on the bottom of page 3 under the Titration Prescription
- Pages 1 to 3 are faxed with patient clinical notes from up to last 3 visits

Upon receipt of your patient’s completed forms, the NORTHERA Support Center will begin a benefits investigation. The Support Center may contact your office via phone or fax to:

- Obtain any information that was left off the Treatment Form
- Request additional information to complete a prior authorization if necessary
- Clarify the prescription

Please advise your patient that the NORTHERA Support Center will be calling to help ensure prompt delivery of his/her NORTHERA prescription, answer his/her questions, and provide ongoing support. Please inform your patient that:

- These calls will appear as 844-601-0101
- The NORTHERA Support Center requires verbal confirmation of the delivery address from your patient prior to mailing his/her medication

Questions? Call toll-free 844-601-0101.
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 my use or potential use of NORTHERA, including my personal contact information on this form (collectively, my “Information”), to 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) contact me regarding my use or potential use of NORTHERA, including through voice-mail messages left for me that disclose that I take or may take NORTHERA; (4) provide me with support communications and services, including facilitating the provision of NORTHERA to me; (5) evaluate the effectiveness of NORTHERA support programs; (6) report safety information, including communications with the US Food and Drug Administration and other government authorities; and (7) share my Information with third-party research organizations so that they may contact me about opportunities to participate in market research activities or for health outcomes research purposes. I understand that if at any time I decide I would prefer not to be contacted for these research purposes, I may opt out of such contacts by calling the NORTHERA Support Center at 844-601-0101, without affecting my authorization for the purposes stated in clauses (1) through (6) above.

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, it will not affect my right to treatment or payment of benefits for healthcare. I also understand that if I sign, I may later withdraw this Authorization by sending written notice of my withdrawal to the Program at Program Administrator, P.O. Box 7526, Gaithersburg, MD 20898, but that such withdrawal will not affect any uses and disclosures of my Information made 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.

AUTHORIZED REPRESENTATIVE CONSENT (OPTIONAL)

I further authorize the NORTHERA Support Center to discuss my treatment with droxidopa 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: ____________________________

PATIENT HIPAA

*PATIENT/_GUARDIAN SIGNATURE: □ Self □ Spouse □ Other*

*PATIENT/_GUARDIAN NAME (PLEASE PRINT): ____________________________

*DATE: ____________________________

*RELATIONSHIP TO PATIENT: □ Self □ Spouse □ Other*

*Please note documentation proving Power of Attorney may be required.
## Patient Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>*DOB MM/DD/YYYY:</td>
<td></td>
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<tr>
<td>*GENDER: M F</td>
<td></td>
</tr>
<tr>
<td>*PRIMARY PHONE:</td>
<td></td>
</tr>
<tr>
<td>Home</td>
<td></td>
</tr>
<tr>
<td>Cell</td>
<td></td>
</tr>
<tr>
<td>Work</td>
<td></td>
</tr>
<tr>
<td>SECONDARY PHONE:</td>
<td></td>
</tr>
<tr>
<td>Home</td>
<td></td>
</tr>
<tr>
<td>Cell</td>
<td></td>
</tr>
<tr>
<td>Work</td>
<td></td>
</tr>
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<td>PREFERRED CONTACT TIME</td>
<td>Morning</td>
</tr>
<tr>
<td>Afternoon</td>
<td></td>
</tr>
<tr>
<td>Evening</td>
<td></td>
</tr>
<tr>
<td>EMAIL:</td>
<td></td>
</tr>
<tr>
<td>*MAILING ADDRESS:</td>
<td></td>
</tr>
<tr>
<td>*CITY:</td>
<td></td>
</tr>
<tr>
<td>*STATE:</td>
<td></td>
</tr>
<tr>
<td>*ZIP CODE:</td>
<td></td>
</tr>
</tbody>
</table>

- Check here if patient is in the hospital. Discharge date: ________________

**PATIENT TO READ AND SIGN HIPAA AUTHORIZATION ON PAGE 1.**

## Patient Insurance

**Complete the information below OR include copies of insurance cards (front and back).**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
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</thead>
<tbody>
<tr>
<td>*PRIMARY INSURANCE COMPANY:</td>
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<tr>
<td>PHONE:</td>
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<tr>
<td>*ID NUMBER:</td>
<td></td>
</tr>
<tr>
<td>CARDHOLDER NAME:</td>
<td></td>
</tr>
<tr>
<td>RELATIONSHIP TO CARDHOLDER:</td>
<td>Self</td>
</tr>
<tr>
<td>Spouse</td>
<td></td>
</tr>
<tr>
<td>Child</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
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<tr>
<td>SECONDARY INSURANCE COMPANY:</td>
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<td>PHONE:</td>
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<td>ID NUMBER:</td>
<td></td>
</tr>
<tr>
<td>CARDHOLDER NAME:</td>
<td></td>
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</tbody>
</table>

**Indicates required field**

## Clinical Information

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

**1) PRIMARY DIAGNOSIS:**

- [ ] G20 Parkinson’s disease
- [ ] G23.2 Striatonigral degeneration
- [ ] G99.0 Autonomic neuropathy in diseases classified elsewhere
- [ ] G90.9 Disorder of the autonomic nervous system, unspecified
- [ ] G90.3 Multi-system degeneration of the autonomic nervous system
- [ ] Other: ________________

**2) SYMPTOMATIC CONDITION(S) (CHECK ALL THAT APPLY):**

- [ ] Neurogenic orthostatic hypotension (currently no nOH-specific ICD-10 code exists)
- [ ] I95.1 Orthostatic hypotension
- [ ] I95.89 Other hypotension
- [ ] R55 Syncope and collapse
- [ ] R42 Dizziness and giddiness
- [ ] Other: ________________

**TREATMENT HISTORY (CHECK ALL THAT APPLY):**

- [ ] Nonpharmacologic therapy
- [ ] Failure or inadequate response
- [ ] Therapy description: ________________
- [ ] Fludrocortisone
- [ ] Failure
- [ ] Inadequate response
- [ ] Contraindication
- [ ] Intolerance
- [ ] Midodrine
- [ ] Failure
- [ ] Inadequate response
- [ ] Contraindication
- [ ] Intolerance
- [ ] No previous therapies have been administered. Please explain: ________________

**ANY KNOWN ALLERGIES:** ________________

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.

**PLEASE INCLUDE PATIENT CLINICAL NOTES (UP TO LAST 3 VISITS)**

*Lundbeck cannot provide free drug to ANY patients residing in a skilled care facility. This includes: skilled nursing facilities, hospitals, and rehabilitation facilities.*
**Prescriber Information**

<table>
<thead>
<tr>
<th><em>PRESCRIBER NAME:</em></th>
<th><em>NPI #:</em></th>
<th><em>STATE ID:</em></th>
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<table>
<thead>
<tr>
<th>SPECIALTY:</th>
<th>Neurologist</th>
<th>Cardiologist</th>
<th>NP/PA</th>
<th>PCP</th>
<th>Autonomic Specialist</th>
<th>Other:</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>PRACTICE/FACILITY NAME:</th>
<th><em>OFFICE CONTACT NAME:</em></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><em>ADDRESS:</em></th>
<th><em>PATIENT PHONE:</em></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><em>CITY:</em></th>
<th><em>STATE:</em></th>
<th><em>ZIP CODE:</em></th>
</tr>
</thead>
</table>

**Titration Prescription**

**Option A**
Increase dose every 24 hours

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Days 6-30&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 mg</td>
<td>200 mg</td>
<td>300 mg</td>
<td>400 mg</td>
<td>500 mg</td>
<td>600 mg</td>
</tr>
</tbody>
</table>

**Option B**
Increase dose every 48 hours

<table>
<thead>
<tr>
<th>Days 1 and 2</th>
<th>Days 3 and 4</th>
<th>Days 5 and 6</th>
<th>Days 7 and 8</th>
<th>Days 9 and 10</th>
<th>Days 11-30&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 mg</td>
<td>200 mg</td>
<td>300 mg</td>
<td>400 mg</td>
<td>500 mg</td>
<td>600 mg</td>
</tr>
</tbody>
</table>

**Option C**
Increase dose per schedule

Take by mouth
Sig:

*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 to (1) perform a preliminary verification of the patient’s insurance coverage for NORTHERA; (2) assess the patient’s eligibility for participation in the Program; (3) enroll the patient in the Program; and (4) provide reimbursement support and other services to the patient in connection with the patient’s NORTHERA therapy. I authorize and appoint the Program to convey on my behalf to a dispensing pharmacy chosen by or for the patient any prescription information I provide to the Program for NORTHERA. I agree that the Program may contact me for additional information relating to the Program or NORTHERA, including but not limited to via email, fax, and telephone.

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DRX-B-00215a 11/2016  www.NORTHERA.com
**NORTHERA® (droxidopa)**

**INDICATIONS AND USAGE**

NORTHERA is indicated for the treatment of orthostatic dizziness, lightheadedness, or the “feeling that you are about to black out” in adult patients with symptomatic neurogenic orthostatic hypotension (nOH) caused by primary autonomic failure (Parkinson’s disease [PD], multiple system atrophy, and pure autonomic failure), dopamine beta-hydroxylase deficiency, and non-diabetic autonomic neuropathy. Effectiveness beyond 2 weeks of treatment has not been established. The continued effectiveness of NORTHERA should be assessed periodically.

**IMPORTANT SAFETY INFORMATION**

**WARNING: SUPINE HYPERTENSION**

Monitor supine blood pressure prior to and during treatment and more frequently when increasing doses. Elevating the head of the bed lessens the risk of supine hypertension, and blood pressure should be measured in this position. If supine hypertension cannot be managed by elevation of the head of the bed, reduce or discontinue NORTHERA.

**CONTRAINDICATIONS**

- NORTHERA is contraindicated in patients who have a history of hypersensitivity to the drug or its ingredients.

**WARNINGS AND PRECAUTIONS**

- **Supine Hypertension:** NORTHERA therapy may cause or exacerbate supine hypertension in patients with nOH, which may increase the risk of cardiovascular events if not well managed.

- **Hyperpyrexia and Confusion:** Cases of a symptom complex resembling neuroleptic malignant syndrome (NMS) have been reported with NORTHERA use during post-marketing surveillance. Observe patients carefully when the dosage of NORTHERA is changed or when concomitant levodopa is reduced abruptly or discontinued, especially if the patient is receiving neuroleptics. NMS is an uncommon but life-threatening syndrome characterized by fever or hyperthermia, muscle rigidity, involuntary movements, altered consciousness, and mental status changes. The early diagnosis of this condition is important for the appropriate management of these patients.

- **Ischemic Heart Disease, Arrhythmias, and Congestive Heart Failure:** NORTHERA therapy may exacerbate existing ischemic heart disease, arrhythmias, and congestive heart failure. Careful consideration should be given to this potential risk prior to initiating therapy.

- **Allergic Reactions:** Hypersensitivity reactions, including anaphylaxis, angioedema, bronchospasm, urticaria, and rash have been reported in post-marketing experience, with some resulting in emergency treatment. If a hypersensitivity reaction occurs, discontinue the drug and initiate appropriate therapy.

This product contains FD&C Yellow No. 5 (tartrazine), which may also cause allergic-type reactions (including bronchial asthma) in certain susceptible persons. Although the overall incidence of FD&C Yellow No. 5 (tartrazine) sensitivity in the general population is low, it is frequently seen in patients who also have aspirin hypersensitivity.

**ADVERSE REACTIONS**

- The most common adverse reactions (≥5% and ≥3% difference compared to placebo) were headache, dizziness, nausea, and hypertension.

**DRUG INTERACTIONS**

- Administering NORTHERA in combination with other agents that increase blood pressure (e.g., norepinephrine, ephedrine, midodrine, and triptans) would be expected to increase the risk for supine hypertension.

- Dopa-decarboxylase inhibitors may require dose adjustments for NORTHERA.

- The concomitant use of selective MAO-B inhibitors, such as rasagiline or selegiline, was permitted in the NORTHERA clinical trials. However, based on mechanism of action, the use of non-selective MAO inhibitors and linezolid should be avoided as there is a potential for increased blood pressure when taken with NORTHERA.

**USE IN SPECIFIC POPULATIONS**

- There are no available data on use of NORTHERA in pregnant women and risk of major birth defects or miscarriage. Because of the potential for serious adverse reactions, including reduced weight gain in breastfed infants, advise a woman not to breastfeed during treatment with NORTHERA.

- The safety and effectiveness of NORTHERA in pediatric patients have not been established. No overall differences in safety or effectiveness were observed between patients aged 75 years and older and younger patients in clinical trials, but greater sensitivity of some older individuals cannot be ruled out.

- Clinical experience with NORTHERA in patients with severe renal function impairment (GFR <30 mL/min) is limited; therefore, dosing recommendations cannot be provided for these patients.

Please see the accompanying full Prescribing Information, including BoxedWarning for supine hypertension, or go to www.NORTHERA.com.

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