

Clinical Policy: Droxidopa (Northera)

Reference Number: CP.PMN.17

Effective Date: 08.01.16

Last Review Date: 11.21

Line of Business: Commercial, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Droxidopa (Northera[®]) is a synthetic amino acid precursor of norepinephrine.

FDA Approved Indication(s)

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.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that Northera is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Neurogenic Orthostatic Hypotension (must meet all):

1. Diagnosis of symptomatic nOH caused by one of the following (a, b, or c):
 - a. Primary autonomic failure (PD, multiple system atrophy, or pure autonomic failure);
 - b. Dopamine beta-hydroxylase deficiency;
 - c. Non-diabetic autonomic neuropathy;
2. Age \geq 18 years;
3. Failure of midodrine or fludrocortisone at up to maximally indicated doses, unless both are contraindicated or clinically significant adverse are experienced;
4. Dose does not exceed 1,800 mg (6 capsules) per day.

Approval duration: 14 days

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Neurogenic Orthostatic Hypotension (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 1,800 mg (6 capsules) per day.

Approval duration: 6 months

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.CPA.09 for commercial and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
nOH: neurogenic orthostatic hypotension
PD: Parkinson's disease

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
midodrine	10 mg PO TID at 3 to 4 hour intervals (during daytime hours)	30 mg/day
fludrocortisone	0.1 to 0.2 mg PO QD	0.2 mg/day

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): history of hypersensitivity to the drug or its ingredients
- Boxed warning(s): supine hypertension

Appendix D: General Information

- Symptoms of nOH may include lightheadedness, dizziness, visual disturbances, presyncope, and syncope in response to sudden postural change.
- Effectiveness of Northera beyond two weeks of treatment has not been established. Per package labeling for Northera, continued effectiveness of Northera should be assessed periodically.
- The package labeling for Northera includes a Black Box warning for reduction or discontinuation of Northera if supine hypertension cannot be managed by elevation of the head of the bed.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
nOH	100 mg PO TID during the day Titrate to symptomatic response, in increments of 100 mg PO TID every 24-48 hours up to a maximum dose of 600 mg PO TID.	1,800 mg/day

VI. Product Availability

Capsules: 100 mg, 200 mg, 300 mg

VII. References

1. Northera Prescribing Information. Deerfield, IL: Lundbeck; July 2019. Available at: <http://www.northera.com>. Accessed August 1, 2021.
2. Vijayan J, Sharma VK. Neurogenic orthostatic hypotension - management update and role of droxidopa. *Ther Clin Risk Manag*. 2015 Jun 8;11:915-23.
3. Jones PK, Shaw BH, Raj SR. Orthostatic hypotension: managing a difficult problem. *Expert Rev Cardiovasc Ther*. 2015 Nov;13(11):1263-76. doi: 10.1586/14779072.2015.1095090. Epub 2015 Oct 1.
4. Shibao C, Lipsitz LA, Biaggioni I et al. Evaluation and treatment of orthostatic hypotension. *J Am Soc Hypertens*. 2013 Jul-Aug;7(4):317-24. doi: 10.1016/j.jash.2013.04.006. Epub 2013 May 27.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Added age and Appendix information re: black box warning. Updated references.	07.01.17	11.17
4Q 2018 annual review: policies combined for Centene Medicaid and Commercial lines of business; Commercial: added requirement for documentation of specific types/etiologies of nOH; changed Initial Approval duration from Length of Benefit to 14 days to match the Medicaid line of business, and due to lack of evidence of effectiveness of Northera after 2 weeks of treatment; changed Continued Therapy approval duration from Length of Benefit to 6 months in order to assess for continued efficacy in light of the black box warning	07.22.18	11.18

Reviews, Revisions, and Approvals	Date	P&T Approval Date
potential for severe supine hypertension with use of Northera; Medicaid: added the Continued Therapy requirement to provide documentation that the member has responded positively to therapy; removed the requirement to wait 365 days before reauthorizing Northera even in cases where efficacy at 14 days has been demonstrated; changed Continued Therapy approval duration from 14 days to 6 months; references reviewed and updated.		
4Q 2019 annual review: no significant changes; references reviewed and updated.	08.13.19	11.19
4Q 2020 annual review: no significant changes; references reviewed and updated.	08.21.20	11.20
4Q 2021 annual review: no significant changes; references reviewed and updated.	08.01.21	11.21

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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