

RADICAVA (edaravone) PRIOR AUTHORIZATION FORM

Radicava and Quantity Limits/Daily Dose Limits prior authorization guidelines are accessible on the Department's Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	Total # of pages: _____	Prescriber name:
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested: Radicava	Strength/dosage form: <input type="checkbox"/> 30 mg/100 ml bag <input type="checkbox"/> _____
Directions:	<input type="checkbox"/> For new starts : 60 mg (200 ml) daily x 14 days followed by a 14-day drug-free period, then 60 mg (200 ml) daily for 10 days out of the next 14-day period followed by a 14-day drug free period
	<input type="checkbox"/> For renewals : 60 mg (200 ml) daily for 10 days out of a 14-day period followed by a 14-day drug free period
	<input type="checkbox"/> other: _____
Diagnosis:	Number of 28-day treatment cycles requested:
Diagnosis:	Qty requested:
Specialty Pharmacy Drug Program:	Radicava is part of the DHS Specialty Pharmacy Drug Program and is only available from one of the two DHS specialty pharmacies – Walgreen's Specialty Pharmacy .
Is Radicava being prescribed by, or in consultation with, a specialist? <i>Submit documentation of consultation, if applicable.</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	

Initial requests

1. Does the beneficiary have results of a baseline evaluation (before starting Radicava) that include a Revised ALS Functional Rating Scale (ALSFRS-R) score or other standardized assessment tool?	<input type="checkbox"/> Yes <i>Submit documentation of a baseline evaluation.</i> <input type="checkbox"/> No
2. Was the beneficiary diagnosed with ALS within the two years before starting Radicava?	<input type="checkbox"/> Yes <i>Submit documentation of dx date or duration of disease.</i> <input type="checkbox"/> No
3. What is the beneficiary's baseline (pre-treatment) FEV ₁ ? FEV ₁ : _____ % Date of result: _____ <i>Submit documentation.</i>	
4. Is the beneficiary dependent on mechanical ventilation by tracheostomy or intubation?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No
5. Does the beneficiary receive tube feedings?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No
6. Will the beneficiary be taking riluzole in addition to Radicava, or does the beneficiary have a clinical reason (such as intolerance, contraindication, or elevated baseline LFTs) for not taking riluzole?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No

Renewal requests

1. Is the beneficiary receiving clinical benefit from Radicava?	<input type="checkbox"/> Yes <i>Submit documentation of beneficiary's clinical response.</i> <input type="checkbox"/> No
2. Does the beneficiary have results of a recent evaluation that include a Revised ALS Functional Rating Scale (ALSFRS-R) score or other standardized assessment tool?	<input type="checkbox"/> Yes <i>Submit documentation of a recent evaluation.</i> <input type="checkbox"/> No
3. Will the beneficiary be taking riluzole in addition to Radicava, or does the beneficiary have a clinical reason (such as intolerance, contraindication, or elevated baseline LFTs) for not taking riluzole?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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