AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Radicava ORS® (edaravone)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable**: _____

Weight (if applicable): _____ **Date weight obtained:** _____

Recommended Dosage:

- 105 mg (5 mL) taken orally or via feeding tube in the morning after overnight fasting
- Initial treatment cycle: daily dosing for 14 days followed by a 14-day drug-free period
- Subsequent treatment cycles: daily dosing for 10 days out of 14-day periods, followed by 14 day drug-free periods

Quantity Limits:

- Radicava ORS® Starter Kit: 70 mL per 365 days
- Radicava ORS® Kit: 50 mL per 28 days

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 6 months (no more than 86 doses over 180 days)

(Continued on next page)

- ❑ Prescribed by or in consultation with a neurologist, a neuromuscular disease specialist, or a physician specializing in the treatment of ALS
- ❑ Member is ≥ 18 years of age
- ❑ Member has a diagnosis of "definite" or "probable" amyotrophic lateral sclerosis (ALS) per the EL Escorial
- ❑ Functionality retained most activities of daily living **(defined as scores of 2 points or better on each individual item of the ALS Functional Rating Scale-Revised (ALSFRS-R)) (must be submitted)**

ALSFRS-R Score For:	Score of 0	Score of 1	Score of 2	Score of 3	Score of 4
Speech Function	❑	❑	❑	❑	❑
Salivation Function	❑	❑	❑	❑	❑
Handwriting Function	❑	❑	❑	❑	❑
Cutting Food Function	❑	❑	❑	❑	❑
Dressing/Hygiene Function	❑	❑	❑	❑	❑
Turning in Bed Function	❑	❑	❑	❑	❑
Walking Function	❑	❑	❑	❑	❑
Climbing Stairs Function	❑	❑	❑	❑	❑
Dyspnea Function	❑	❑	❑	❑	❑
Orthopnea Function	❑	❑	❑	❑	❑
Respiratory Insufficiency Function	❑	❑	❑	❑	❑
Swallowing Function	❑	❑	❑	❑	❑

****Check the ALSFRS-R score that correlates to the patient for each of the following functions above; Provider please note:** Radicava ORS® is considered an **exclusion for score of 3 or less on ALSFRS-R items** for dyspnea, orthopnea, or respiratory insufficiency; history of spinal surgery after onset of ALS ******

- ❑ Member has normal respiratory function confirmed by a % forced vital capacity (%FVC) ≥ 80% at the start of treatment **(medical records must be attached; records attached must have been completed within the last 6 months)**
- ❑ Member has a disease duration of two (2) years or less **(progress notes must document date)**
- ❑ Member has no history of spinal surgery after onset of ALS

(Continued on next page)

- ❑ Medication will be used in combination with riluzole unless patient has an FDA labeled contraindication or intolerance to riluzole **(explain the intolerance or contraindication if applicable)**:

  _____

  _____

  _____

Reauthorization: 12 months (no more than 86 doses over 180 days). All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member must meet **ALL** the following:
  - ❑ Member meets all initial authorization requirements
  - ❑ Member does **NOT** require invasive ventilation
  - ❑ According to the prescriber, the member continues to benefit from therapy

Medication being provided by Specialty Pharmacy – Proprium Rx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*