SENTARA COMMUNITY PLAN
(MEDICAID)

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 1-800-750-9692**. 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 Sentara #: ____________________ **Date of Birth:** ____________

Prescriber Name: ______________________________

Prescriber Signature: ____________________ **Date:** ____________

Office Contact Name: ______________________________

Phone Number: ____________________ **Fax Number:** ____________

DEA OR NPI #: ______________________________

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: ______________________________

Dosing Schedule: ____________________ **Length of Therapy**: ____________

Diagnosis: ____________________ **ICD Code, if applicable:** ____________

Weight: ____________________ **Date:** ____________

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

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- ❑ Prescriber is a Neurologist
- ❑ 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)**
- ❑ Normal respiratory function confirming member has a % forced vital capacity (%FVC) ≥ 80% at the start of treatment **(medical records must be attached)**
- ❑ Disease duration of two (2) years or less **(progress notes must document date)**
- ❑ 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

Reauthorization: 6 months (no more than 86 doses over 180 days). 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.

- ❑ Functionality retained most activities of daily living (defined as score from baseline did not decrease on each individual item of the ALS Functional Rating Scale-Revised (ALSFRS-R)
- ❑ Normal respiratory function confirming the Member has a % forced vital capacity (%FVC) ≥ 80%

Medication being provided by Specialty Pharmacy - PropriumRx

*****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.****

***Approved by Pharmacy and Therapeutics Committee**: 7/21/2022
REVISED/UPDATED/REFORMATTED: ~~8/5/2022;~~ **11/09/2023**