

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:** _____

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)

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- 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salivation Function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Handwriting Function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cutting Food Function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing/Hygiene Function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turning in Bed Function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking Function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs Function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dyspnea Function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orthopnea Function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Insufficiency Function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing Function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

****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) $\geq 80\%$ 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

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- 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.****