

SENTARA COMMUNITY PLAN (MEDICAID)

MEDICAL 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 1-844-305-2331. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If information provided is not complete, correct, or legible, authorization can be delayed.

Drug Requested: edaravone IV (Radicava®) (J1301) (Medical)

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: _____

- Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Recommended Dosing:

<input type="checkbox"/> 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	Number of 28-day treatment cycles requested: _____
<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	

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Which of the following diagnosis does the patient have based on the El Escorial revised Criteria? **(select one)**

- Clinically Defined ALS
 Clinically Probable ALS
 Clinically Probable-Laboratory ALS
 Clinically Possible ALS
 Clinically Suspected ALS

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)

- Prescriber is a neurologist
 Member is \geq 18 years of age
 Member has diagnosis of “definite” or “probable” amyotrophic lateral sclerosis (ALS) per the EL Escorial
 Functionality retained on 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) with the exception of dyspnea, orthopnea, and respiratory insufficiency which must be a score of 4) (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****

- 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 SIX months)**
 Member has a disease duration of two (2) years or less **(progress notes must document date)**

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- Member has no history of spinal surgery after onset of ALS
- 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 checked for approval. To support each line checked, all documentation (lab results, diagnostics, and/or chart notes) must be provided or request may be denied.

- Provider must submit documentation to confirm member is benefiting from therapy (e.g. slowing in the decline of functional abilities, and change in ALSFRS-R score has not changed -7 points from last request) (**must submit recent ALSFRS form**)
- Member has normal respiratory function confirmed by a % forced vital capacity (%FVC) \geq 70%
- Member's ALSFRS-R score for dyspnea, orthopnea, and respiratory insufficiency is 4
 Yes No
- 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**):

Medication being provided by (check applicable box below):

- Location/site of drug administration:** _____
NPI or DEA # of administering location: _____

OR

- Specialty Pharmacy – Proprium Rx**

For urgent reviews: Practitioner should call Sentara Health Plans Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health Plan's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****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.****