

# AvMed

## 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 1-877-535-1391**. 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.**

**For Medicare Members:** Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. Additional indications may be covered at the discretion of the health plan.

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

**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: \_\_\_\_\_

- 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"/> <b>New starts:</b> 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"/> <b>For renewals:</b> 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)**

- Prescribed by or in consultation with a neurologist, a neuromuscular disease specialist, or a physician specializing in the treatment of ALS  
 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) (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"/>				
Salivation Function	<input type="checkbox"/>				
Handwriting Function	<input type="checkbox"/>				
Cutting Food Function	<input type="checkbox"/>				
Dressing/Hygiene Function	<input type="checkbox"/>				
Turning in Bed Function	<input type="checkbox"/>				
Walking Function	<input type="checkbox"/>				
Climbing Stairs Function	<input type="checkbox"/>				
Dyspnea Function	<input type="checkbox"/>				
Orthopnea Function	<input type="checkbox"/>				
Respiratory Insufficiency Function	<input type="checkbox"/>				
Swallowing Function	<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 6 months)**

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- 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
- 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**):

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**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.

- 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 (check applicable box below):**

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

**OR**

- Specialty Pharmacy**

For urgent reviews: Practitioner should call AvMed Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed'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.\****