pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

RADICAVA (edaravone) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for Radicava (edaravone) and Quantity Limits are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested / directions:

☐Radicava ORS suspension starter kit (1 kit = 70 mL)

☐Initial treatment cycle: 105 mg (5 mL) daily x 14 days followed by a 14-day drug-free period *(1 kit of 70 mL = 1st 28-day treatment cycle)*

☐Radicava ORS 105 mg/5 mL suspension (1 bottle = 50 mL)

☐Subsequent treatment cycles: 105 mg (5 mL) daily for 10 days out of a 14-day period followed by a 14-day drug free period *(1 bottle of 50 mL = 1 subsequent 28-day treatment cycle)*

☐Radicava 30 mg/100 mL bag (1 bag = 100 mL)

☐Initial treatment cycle: 60 mg (200 mL) daily x 14 days followed by a 14-day drug-free period *(28 x 100 mL bags = 1st 28-day treatment cycle)*

☐Subsequent treatment cycles: 60 mg (200 mL) daily for 10 days out of a 14-day period followed by a 14-day drug free period *(20 x 100 mL bags = 1 subsequent 28-day treatment cycle)*

☐Other (specify): _____

_____

Number of 28-day treatment cycles requested: ☐initial treatment cycles: 1 ☐subsequent treatment cycles: _____

Diagnosis *(submit documentation)*:	Dx code *(required)*:
SPECIALTY PHARMACY DRUG PROGRAM: Radicava is included in the DHS Specialty Pharmacy Drug Program and is available from DHS's specialty pharmacy. Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Specialty-Pharmacy-Program.aspx for more information about the Specialty Pharmacy Drug Program.	DHS specialty pharmacy: Chartwell Pennsylvania, LP Oakdale, PA Phone: 833-710-0211 Fax: 412-920-1869 www.chartwellpa.com

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

Is Radicava being prescribed by or in consultation with a specialist?	☐Yes ☐No *Submit documentation of consultation, if applicable.*
INITIAL requests	
Does the beneficiary have results of a baseline evaluation (before starting Radicava) that include a Revised ALS Functional Rating Scale (ALSFRS-R) score or other standardized assessment tool?	☐Yes ☐No *Submit documentation of a baseline evaluation.*
Was the beneficiary diagnosed with ALS within the two years before starting Radicava?	☐Yes ☐No *Submit documentation of dx date or duration of disease.*
What is the beneficiary's baseline (pre-treatment) FEV_1? FEV_1: _____ % Date of result: _____	*Submit documentation.*
Is the beneficiary dependent on mechanical ventilation by tracheostomy or intubation?	☐Yes ☐No *Submit documentation.*
Does the beneficiary receive tube feedings?	☐Yes ☐No *Submit documentation.*
Will the beneficiary be taking riluzole in addition to Radicava, or does the beneficiary have a clinical reason (such as intolerance, contraindication, or elevated baseline LFTs) for not taking riluzole?	☐Yes ☐No *Submit documentation.*
RENEWAL requests	
Is the beneficiary receiving clinical benefit from Radicava?	☐Yes ☐No *Submit documentation of beneficiary's clinical response.*
Does the beneficiary have results of a recent evaluation that include a Revised ALS Functional Rating Scale (ALSFRS-R) score or other standardized assessment tool?	☐Yes ☐No *Submit documentation of a recent evaluation.*
Will the beneficiary be taking riluzole in addition to Radicava, or does the beneficiary have a clinical reason (such as intolerance, contraindication, or elevated baseline LFTs) for not taking riluzole?	☐Yes ☐No *Submit documentation.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date: