AvMed

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 1-305-671-0200**. 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 AvMed #: _____ **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/REFORMATTED/UPDATED: ~~8/5/2022,~~ **10/30/2023**