Hy-Vee health

RADICAVA (EDARAVONE)
Infusion Orders

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Patient Name: ______________________ **DOB:** __________ **Phone:** __________

Patient Status: New to Therapy Continuing Therapy **Next Treatment Date:** __________

Medical Information

Diagnosis: Amyotrophic lateral sclerosis (ALS) **ICD-10 Code:** G12.21

Other ______________________ **ICD-10 Code:** __________

Patient Weight: ________ lbs. (required) **Allergies:** ______________________

Therapy Order

Radicava:

Initial treatment cycle: 60 mg IV daily for 14 days followed by 14-day drug-free period

Maintenance dosing: 60 mg IV daily for 10 days, out of 14-day period, followed by 14-day drug-free period x1 year

Additional orders: ______________________

Lab Orders: ______________________

Lab Frequency: ______________________

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
  - 15-30kg (33-66lbs): EpiPen Jr. 0.15 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50 mg orally (adult)
- Refer to physician order or institutional protocol for pediatric dosing as applicable

Flush orders: NS 1-20 mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

Provider Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: ______________________ **Signature:** ______________________ **Date:** __________

Provider NPI: __________ **Phone:** __________ **Fax:** __________ **Contact Person:** __________

Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): ______________________

Service Areas

Des Moines, IA West Des Moines, IA Chicago, IL Omaha, NE Buffalo, NY Dallas, TX

Phoenix, AZ Other __________

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COMPREHENSIVE SUPPORT FOR RADICAVA THERAPY

Patient Information

Patient Name: ______________________ **DOB:** ______________________

Required Documentation for Referral Processing & Insurance Approval

Include signed and completed order (MD/prescriber to complete page 1)

Include patient demographic information and insurance information

Include patient's medication list

Searchlight ID/Forms

Supporting clinical notes (H&P) to support primary diagnosis, including:

- ALS diagnosis date: ______________________
- Pulmonary Function Tests (PFTs), including forced vital capacity (FVC)
- ALSFRS-R (Revised Amyotrophic Lateral Sclerosis Functional Rating Scale): ______________________
- Baseline EMG

Has the patient tried and failed Riluzole? Yes No **OR** currently taking?

Does the patient depend on invasive ventilation or tracheostomy? Yes No

Other medical necessity: ____

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

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