Updated: 05/2019
DMMA Approved: 05/2019

Request for Prior Authorization for Radicava (edaravone)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Radicava (edaravone) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Radicava (edaravone) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of amyotrophic lateral sclerosis (ALS) and the following criteria is met:

- Must be at least 18 years of age
- Must have a disease duration of less than 2 years
- Must have a forced vital capacity (FVC) ≥ 80%
- Must be able to perform activities of daily living (ADLs) such as eating and moving around independently
- Provide an ALSFRS-R score within the past 6 months
- Must be prescribed by or in consultation with a neurologist
- Must be used in combination with riluzole unless there is documentation of intolerance or contraindication to riluzole
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
    - Continues to experience clinical benefit based on the prescriber's assessment
    - Provide an ALSFRS-R score within the past 12 months
    - Continues to use in combination with riluzole unless there is documentation of intolerance or contraindication to riluzole
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

HIGHMARK. Delaware HEALTH OPTIONS

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RADICAVA (EDARAVONE)
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6253 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: ☐ Amyotrophic Lateral Sclerosis (ALS) ☐ Other: _____ ICD-10 Code: _____
Duration of disease: ☐ Less than 2 years ☐ 2 or more years
ALSFRS-R Score: **Forced vital capacity (FVC):** **%**

Is the member able to perform activities of daily living (ADLs) such as eating and moving around independently?
☐ Yes ☐ No

Will this be used in combination with riluzole? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced clinical benefit with treatment? ☐ Yes ☐ No

ALSFRS-R Score:

Is this being used in combination with riluzole? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date