

Prior Authorization Criteria
Radicava (edaravone)

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

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) \geq 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.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.



Updated: 05/2019
PARP Approved: 06/2019

**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 Gateway HealthSM Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 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:
Gateway ID:	Member weight: _____ pounds or _____ kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date Medication Initiated:	

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

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