PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Radicava (edaravone)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is the patient being treated for definite or probable Amyotrophic lateral sclerosis (ALS), based on el Escorial revised criteria? (Please submit clinical documentation to support diagnosis)

☐ Yes ☐ No

Q2. Please provide ICD code(s) for diagnosis.

Q3. Is the prescriber a Neurologist?

☐ Yes ☐ No

Q4. Is the patient ≥18 years of age?

☐ Yes ☐ No

Q5. Is the patient's functionality retained for most activities of daily living, as demonstrated by a score of 2 or more on each item of the ALS Functional Rating Scale- revised (ALSFRS-R)?

☐ Yes ☐ No

Q6. Does the patient have normal respiratory function, defined as an FVC of at least 80%?

☐ Yes ☐ No

Q7. Has patient had disease duration of two years or less?

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☐ Yes ☐ No

Q8. Has the patient failed, or does the patient have an intolerance or will member continue on riluzole? (Please specify)

☐ Yes ☐ No

Q9. How will drug be billed?

☐ Pharmacy claim (drug to be billed as a PHARMACY benefit claim and dispensed by pharmacy directly to member)

☐ Pharmacy claim (drug to be billed as a PHARMACY benefit claim, but shipped direct to provider to be administered to this specific member)

☐ MEDICAL claim (drug to be billed by PROVIDER as a MEDICAL benefit claim as an expense to the provider, and provider to supply drug to member)

Q10. If billing as a MEDICAL claim, what provider will be linked to the claim (i.e. who is the billing entity seeking reimbursement)? Provide Name and NPI

☐ Individual prescriber

☐ Provider or specialty group

☐ Facility

Q11. Additional Comments

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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