OPTIMA HEALTH COMMUNITY CARE

(MEDICAID)

PHARMACY/MEDICAL 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 1-844-348-3720**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay authorization process.**

Drug Requested: **Radicava™** (edaravone) **IV (Codes C9399/J3490) (Medical)**

DRUG INFORMATION: Complete information below or authorization process will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable**: _____

CLINICAL CRITERIA: **ALL** information below **MUST** be checked to qualify or authorization process will be delayed. Submission of medical records (e.g., chart notes, previous medical history, diagnostic testing to include imaging, nerve conduction studies, lab values) **MUST** be submitted with this request**.**

Initial Approval – Length is for 6 months
(no more than 86 doses over 180 days)

- ❑ **Prescriber is an Neurologist**
  - ❑ Patient is ≥ 18 years of age
  - ❑ Patient has diagnosis of "definite" or "probable" amyotrophic lateral sclerosis (ALS) per the EL Escorial

AND

  - ❑ 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) **(please submit)**

AND

  - ❑ Normal respiratory function confirming patient has a % forced vital capacity (%FVC) ≥ 80% at the start of treatment **(medical records must be attached)**

AND

    - ❑ Disease duration of two (2) years or less **(progress notes must document date)**

Radicava™ 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 Approval – Length is for 6 months
(no more than 86 doses over 180 days)

- ❑ 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)

(continued on next page)

AND

- ❑ Normal respiratory function confirming the patient has a % forced vital capacity (%FVC) ≥ 80%.

Medication being provided by (check applicable box below):

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  OR

- ❑ **Physician's office** **OR** ❑ **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.*

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____)_____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: ~~12/30/2017; 5/25/2018; 8/29/2018; 10/8/2018;~~ **(REFORMATTED) 2/6/2019**