

# OPTIMA HEALTH COMMUNITY CARE

## 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: \_\_\_\_\_

***Medication can only be provided by the Physician's office.\****

***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  $\geq 18$  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)  $\geq 80\%$  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))

**AND**

- Normal respiratory function confirming the patient has a % forced vital capacity (%FVC)  $\geq 80\%$ .

(signature on next page)

**\*\*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.