OPTIMA HEALTH PLAN

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 1-844-723-2094. 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)

AND

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

(signature on next page)

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 #: _____

***Approved by Pharmacy and Therapeutics Committee**: 8/17/2017
REVISED/UPDATED: ~~9/28/2017; 12/30/2017;~~ **5/24/2018**;