PriorityHealth

Medical prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Radicava® (endaravone)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Phys. Phone: _____ Phys. Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

☐ New Request ☐ Continuation Request

Drug product: ☐ Radicava 30mg/100mL solution

ICD-10 Diagnosis code(s): _____
Dose:_____ **Dose Frequency**:_____
Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Date of next dose: _____

Place of administration:
☐ Physician's office
☐ Outpatient infusion
Facility: _____ NPI:_____ Fax:_____
☐ Home infusion
Agency: _____ NPI:_____ Fax:_____

Billing:
☐ Physician to buy and bill
☐ Facility to buy and bill
☐ Specialty Pharmacy
Pharmacy:_____ NPI:_____ Fax:_____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Diagnosis of "definite" or "probable" amyotrophic lateral sclerosis (ALS) as defined by the revised El Escorial World Federation of Neurology /Arlie House criteria
   - Please provide clinical documentation to support
2. Disease duration of ≤ 2 years
   - Please provide date of diagnosis
3. Age 20 to 75 years
4. Living independently
5. Score of ≥ 2 on each individual item of the revised ALS functional rating scale (ALSFRS-R)
   - Please provide a completed copy of ALSFRS-R
6. Forced vital capacity (FVC) ≥ 80%

All fields must be complete and legible for review. Your office will receive a response via fax.

New 09/2018
Last reviewed 01/2021

If the above criteria are met, initial approval will be for a total of 6 treatment cycles for 6 months. For continuation (one additional 6-month approval), patient must have met the following requirements:

1. FCV of greater than or equal to 30%, does not require tracheostomy/artificial ventilation, and is not on continuous Bilevel Positive Airway Pressure (BiPAP)
2. Ambulatory (able to walk with or without assistance)
3. Able to self-feed

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ "Definite" or "Probable" ALS
☐ Other – rationale for use: _____

B. Has clinical documentation been provided to support diagnosis of "definite" or "probable" ALS?

☐ Yes ☐ No

C. Disease duration

☐ Less than or equal to 2 years Date of diagnosis _____

☐ Greater than 2 years Date of diagnosis _____

D. Is the patient currently living independently?

☐ Yes ☐ No

E. Has a completed copy of the patient's ALSFRS-R been provided?

☐ Yes ☐ No

F. Does the patient have a score of ≥ 2 on each individual ALSFRS-R item?

☐ Yes ☐ No

G. What is the patient's FVC?

☐ FVC _____ Date _____

For continuation of previously authorized requests:

H. Does the patient have FCV of greater than or equal to 30%, does not require tracheostomy/artificial ventilation, and is not on continuous Bilevel Positive Airway Pressure (BiPAP)?

☐ Yes ☐ No

I. Is the patient ambulatory (able to walk with or without assistance)?

☐ Yes ☐ No

J. Is the patient able to self-feed?

☐ Yes ☐ No

Authorized dosing:
Initial cycle: 60mg IV infusion daily for 14 days, followed by a 14-day drug-free period.
Subsequent cycles: 60mg IV infusion daily 10 days out of 14-day periods, followed by 14-day drug-free periods.

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