PriorityHealth

Medicare Part B Prior Authorization Form

Fax completed form to: 877 974-4411 toll free, or 616 942-8206

This form applies to: ☒ **Medicare Part B**

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™ (edaravone)

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 - **Original therapy start date**: _____

Drug product: ☐ Radicava 30mg/100mL injection

Date of last dose (if applicable): _____

Date of next dose (if applicable): _____

Dose: _____ **Dose Frequency**: _____

Number of doses/cycles/duration requested: _____

Patient Dosing Information:

Height: _____ Weight: _____ BSA: _____

Place of administration:

☐ Patient self-administration

☐ Physician's office

☐ Outpatient infusion

Facility: _____ NPI: _____ Fax: _____

☐ Home infusion

Facility: _____ NPI: _____ Fax: _____

Billing:

☐ Physician to buy and bill

☐ Facility to buy and bill

☐ **/cycles/duration** Specialty Pharmacy

Pharmacy: _____ NPI: _____ Fax: _____

HCPCS Code: _____

ICD-10 Diagnosis code(s): _____

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

Updated 06/2020
Last reviewed 06/2020

Precertification Requirements

NOTE: Step therapy (trial with the below listed drug(s)) is only applicable to members who are enrolled in an MAPD (Medicare Advantage Prescription Drug) plan.

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

1. Must be used for a medically accepted indication*

Medically accepted indication*

This drug is only covered under Medicare Part B when it is used for a medically accepted indication.
A medically accepted indication for a drug or biologic (that is not a part of an anti-cancer regimen) is a use that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — *supported* by certain references, taking into consideration the major drug compendia (e.g. American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor), authoritative medical literature, and/or accepted standards of medical practice.

National and Local Coverage Determination Criteria

Priority Health Medicare applies CMS national coverage determination (NCD) and local coverage determination (LCD) criteria for Part B (medical) drugs. If no NCD or LCD criteria are available for the state in which the member is receiving the services, the medication must be being used for a medically-accepted indication* as defined in the Medicare Benefit Policy Manual Chapter 15 § 50.

For additional indications and/or criteria not listed on this form, the following NCD and/or LCD criteria apply:

LCD: N/A

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Amyotrophic lateral sclerosis (ALS[1])
☐ Other – rationale for use: _____

Are you asking for an exception to the above list of diagnoses?

☐ Yes. ***Rationale for exception***: _____
☐ No

Priority Health Medicare Exception Request *(exceptions to the above criteria)*

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Radicava likely be the most effective option for this patient?
☐ No
☐ Yes, because: _____

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If the patient is currently using Radicava, would changing the patient's current regimen likely result in adverse effects for the patient?

☐ No
☐ Yes, because:_____

Other information

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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Updated 06/2020
Last reviewed 06/2020