



**RADICAVA (edaravone) PRIOR AUTHORIZATION FORM** (form effective 1/24/2025)

Prior authorization guidelines for Radicava (edaravone) and Quantity Limits/Daily Dose Limits are available on the DHS Pharmacy Services website at <https://www.pa.gov/en/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services.html>.

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:	NPI:	State license #:	
LTC facility contact/phone:	Street address:		
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

**CLINICAL INFORMATION**

Drug/formulation (bag, suspension, vial, etc.) requested:	Strength:
Dose/directions: <u>Initial treatment cycle:</u> <input type="checkbox"/> 105 mg daily x 14 days followed by a 14-day drug-free period <input type="checkbox"/> 60 mg daily x 14 days followed by a 14-day drug-free period <input type="checkbox"/> other: _____ <u>Subsequent treatment cycles:</u> <input type="checkbox"/> 105 mg daily for 10 days out of a 14-day period followed by a 14-day drug free period <input type="checkbox"/> 60 mg daily for 10 days out of a 14-day period followed by a 14-day drug free period <input type="checkbox"/> other: _____	
Number of 28-day treatment cycles requested: <input type="checkbox"/> initial treatment cycles: <u>1</u> <input type="checkbox"/> subsequent treatment cycles: _____	
Diagnosis ( <u>submit documentation</u> ):	Dx code ( <u>required</u> ):
Is edaravone being prescribed by or in consultation with a specialist?	<input type="checkbox"/> Yes <i>Submit documentation of consultation, if applicable.</i> <input type="checkbox"/> No
<b>INITIAL requests</b>	
Does the beneficiary have results of a baseline evaluation (before starting edaravone) that include a Revised ALS Functional Rating Scale (ALSFRS-R) score or other standardized assessment tool?	<input type="checkbox"/> Yes <i>Submit documentation of a baseline evaluation.</i> <input type="checkbox"/> No
Was the beneficiary diagnosed with ALS within the two years before starting edaravone?	<input type="checkbox"/> Yes <i>Submit documentation of dx date or duration of disease.</i> <input type="checkbox"/> No



What is the beneficiary's baseline (pre-treatment) FEV <sub>1</sub> ? FEV <sub>1</sub> : _____ % Date of result: _____ <i>Submit documentation.</i>	
Is the beneficiary dependent on mechanical ventilation by tracheostomy or intubation?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No
Does the beneficiary receive tube feedings?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No
Will the beneficiary be taking riluzole in addition to edaravone, or does the beneficiary have a clinical reason (such as intolerance, contraindication, or elevated baseline LFTs) for not taking riluzole?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No
<b>RENEWAL requests</b>	
Is the beneficiary receiving clinical benefit from edaravone?	<input type="checkbox"/> Yes <i>Submit documentation of beneficiary's clinical response.</i> <input type="checkbox"/> No
Does the beneficiary have results of a recent evaluation that include a Revised ALS Functional Rating Scale (ALSFRS-R) score or other standardized assessment tool?	<input type="checkbox"/> Yes <i>Submit documentation of a recent evaluation.</i> <input type="checkbox"/> No
Will the beneficiary be taking riluzole in addition to edaravone, or does the beneficiary have a clinical reason (such as intolerance, contraindication, or elevated baseline LFTs) for not taking riluzole?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No
<b>PLEASE FAX COMPLETED FORM WITH <u>REQUIRED CLINICAL DOCUMENTATION</u> TO DHS – PHARMACY DIVISION</b>	
Prescriber Signature:	Date:

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