PARAGON HEALTHCARE

A Carelon Company

RADICAVA (EDARAVONE) INFUSION ORDERS

P: 877.365.5566 | **F:** 855.889.2946

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 855.889.2946

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Diagnosis: ☐ Amyotrophic Lateral Sclerosis (ALS) **ICD-10 Code**: G12.21

☐ Other: _____ **ICD-10 Code**: _____

Patient Weight: _____ lbs. (required) Allergies: _____

THERAPY ORDER

Radicava:

☐ **Initial treatment cycle:** 60mg IV daily for 14 days followed by 14-day drug free period

☐ **Maintenance Dosing:** 60mg IV daily for 10 days out of 14-day period, followed by 14 day drug free period x 1 year

Additional orders: _____

Lab orders: _____ **Lab frequency:** _____

Anaphylactic Reaction Orders (first dose home patients):

- Epinephrine (based on patient weight)
- >30kg (>66lbs): EpiPen 0.3mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
- 15-30kg (33-66lbs): EpiPen Jr. 0.15mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50mg orally (adult)
- Refer to physician order or institutional protocol for pediatric dosing as applicable

Flush orders: NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Paragon selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

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COMPREHENSIVE SUPPORT FOR RADICAVA THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Searchlight ID/Forms
- ☐ Supporting clinical notes (H&P) to support primary diagnosis - Including:
  - ☐ ALS diagnosis date: _____
  - ☐ Pulmonary function tests (PFTs) including forced vital capacity (FVC)
  - ☐ ALSFRS-R (Revised Amyotrophic Lateral Sclerosis Functional Rating Scale): _____
  - ☐ Baseline EMG
- ☐ Has the patient tried and failed Riluzole? ☐ Yes ☐ No **OR** currently taking? ☐ Yes ☐ No
- ☐ Does the patient depend on invasive ventilation or tracheostomy? ☐ Yes ☐ No
- ☐ Other medical necessity: _____

Paragon Healthcare will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (855) 889-2946 or call (877) 365-5566 for assistance