PRIOR AUTHORIZATION REQUEST

RADICAVA

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is this request for INITIAL or CONTINUATION of therapy?

[] Initial (If checked, go to 8)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 8.]

If you have any questions, call: 1-888-258-8250

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3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 8.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 8.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 8.]	Yes	No
6	Does the patient require invasive ventilation? [If yes, no further questions.]	Yes	No
7	Has documentation been submitted to confirm that the patient has had a significant response to therapy, defined as a score of two points or more on each item of the Amyotrophic Lateral Sclerosis (ALS) Functional Rating Scale Revised (ALSFRS-R) (for example, has retained most or all activities of daily living)? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
8	What is the diagnosis or indication? [] Amyotrophic Lateral Sclerosis (ALS) (If checked, go to 9) [] Other (If checked, no further questions)		
9	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
10	According to the prescriber, does the patient have a “definite” or “probable” diagnosis of amyotrophic lateral sclerosis (ALS) based on the application of the E1 Escorial or the revised Airlie House diagnostic criteria? [If no, no further questions.]	Yes	No
11	Does the patient have a score of two points or more on each item of the amyotrophic lateral sclerosis (ALS) Functional Rating Scale Revised (ALSFRS-R) (for example, has retained most or all activities of daily living)? [If no, no further questions.]	Yes	No
12	Does the patient have a percent-predicted forced vital capacity (FVC) GREATER THAN OR EQUAL TO 80 percent (for example, has normal respiratory function)? [If no, no further questions.]	Yes	No
13	Is the patient dependent on invasive ventilation or tracheostomy? [If yes, no further questions.]	Yes	No

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14	Has the patient been diagnosed with amyotrophic lateral sclerosis (ALS) for LESS THAN OR EQUAL TO 2 years? [If no, no further questions.]	Yes	No
15	Is the patient currently receiving riluzole tablets, Tiglutik (riluzole oral suspension), or Exservan (riluzole oral film)? [If no, no further questions.]	Yes	No
16	Is the requested medication prescribed by or in consultation with a neurologist, a neuromuscular disease specialist, or a physician specialized in the treatment of Amyotrophic Lateral Sclerosis (ALS)? [If no, no further questions.]	Yes	No
17	Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved label dosing for indication?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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