Radicava

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical (POS Code 24)*
❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)*
❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

What is the ICD-10 code? _____

Criteria Questions:

1. What is the diagnosis?

❒ Amyotrophic lateral sclerosis (ALS), *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

2. Is the requested medication being prescribed by or in consultation with a neurologist, neuromuscular specialist, or physician specializing in the treatment of amyotrophic lateral sclerosis (ALS)?

❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

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3. Is this request for continuation of therapy with the requested medication?
❒ Yes, *Continue to 7*
❒ No, *Continue to 4*

4. Is the diagnosis classified as definite or probable ALS? ***ACTION REQUIRED***: If Yes, attach clinical documentation (e.g., medical history and diagnostic testing including, nerve conduction studies, imaging and laboratory values to support the diagnosis) supporting the diagnosis or possible diagnosis of amyotrophic lateral sclerosis.
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Does the patient have scores of at least 2 points on all 12 areas of the revised ALS Functional Rating Scale (ALSFRS-R)? ***ACTION REQUIRED***: If Yes, attach clinical documentation supporting the ALS Functional Rating Scale results.
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Does the patient require continuous use of ventilatory support during the day and night (noninvasive or invasive)?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

7. Is the diagnosis classified as definite or probable ALS? ***ACTION REQUIRED***: If Yes, attach clinical documentation (e.g., medical history and diagnostic testing including, nerve conduction studies, imaging and laboratory values to support the diagnosis) supporting the diagnosis or possible diagnosis of amyotrophic lateral sclerosis.
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Is treatment with the requested medication providing a clinical benefit? ***ACTION REQUIRED***: If Yes, attach clinical documentation (e.g., chart notes/medical records) supporting the patient is receiving a clinical benefit from use of the requested drug.
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Does the patient require invasive ventilatory support (e.g., tracheostomy and mechanical ventilation)?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Is the patient currently receiving the requested medication?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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