Radicava (edaravone)

Order Form
Rev. 5/11/2023

Infusion ASSOCIATES
Phone: (833) 394-0600
Fax: (833) 996-4888

PATIENT INFORMATION **Referral Status:** ◉ New Referral ○ Updated Order ○ Order Renewal

Date: Patient Name: DOB:

Allergies: Weight (kg): Height (cm):

ICD-10 Code(s) & Description *(required)*:

☐ *(required)* The patient's demographics, insurance, lab results, meds and recent visit notes were sent to IA.

The patient has an existing prior authorization: ◉ Yes *(please fax IA a copy)* ◉ No *(IA will process for you)*

PRESCRIBING OFFICE

Contact Name: Contact Phone Number:

Ordering Provider: Provider NPI:

Practice Name: Phone: Fax:

CLINICAL HISTORY

In the past year, what medications for the above diagnosis has the patient tried and failed?

Drug & Dose	Dates of Use	Drug & Dose	Dates of Use

Have the Searchlight enrollment forms been submitted? ○ Yes ○ No

Searchlight patient ID#: _____

What is the patient's ALS score?:

ALSFRS-R: _____ **OR** Japanese ALS severity scale with grade 1 or 2: _____

THERAPY ADMINISTRATION

Radicava (edaravone) IV

Dose:

○ **Initial:** 60 mg daily for 14 consecutive days, followed by a 14-day drug-free period

○ **Maintenance:** 60 mg daily for 10 of 14 days, followed by a 14-day drug-free period, repeat every 28 days

Date of last infusion if not at IA: _____ RX Expiration Date: _____

Additional Notes from Referring Office:

_____ _____ _____

Provider Name (Print) **Provider Signature** **Date**