Radicava, edaravone

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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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*

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Radicava edaravone 1961-A SGM SOC 5405-A- 02/2025.

Site of Service Questions (SOS):

A. Where will this drug be administered?
- ❑ Ambulatory surgical, *skip to Clinical Criteria Questions*
- ❑ Home infusion, *skip to Clinical Criteria Questions*
- ❑ Off-campus Outpatient Hospital, *Continue to B*
- ❑ On-campus Outpatient Hospital, *Continue to B*
- ❑ Physician office, *skip to Clinical Criteria Questions*
- ❑ Pharmacy, *skip to Clinical Criteria Questions*

B. Is the patient less than 14 years of age?
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to C*

C. Is this request to continue previously established treatment with the requested medication? ***ACTION REQUIRED: If No, please attach supporting clinical documentation.***
- ❑ Yes - This is a continuation of an existing treatment., *Continue to D*
- ❑ No - This is a new therapy request (patient has not received requested medication in the last 6 months)., *skip to Clinical Criteria Questions*

D. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of the infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to E*

E. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation.
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to F*

F. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to G*

G. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to H*

H. Are all alternative infusion sites (pharmacy, physician office, ambulatory care, etc.) greater than 30 miles from the patient's home? ***ACTION REQUIRED: If Yes, please attach supporting documentation.***
- ❑ Yes, *continue to Clinical Criteria Questions*
- ❑ No, *continue to Clinical Criteria Questions*

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Criteria Questions:

1. What is the diagnosis?

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

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

2. Will the requested medication be 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*

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 (e.g., medical history and/or diagnostic testing including nerve conduction studies, imaging, and laboratory values to support the diagnosis)? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation supporting the diagnosis of definite or probable ALS.
❒ 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 supporting chart notes or medical record documentation of ALS Functional Rating Scale (ALSFRS-R) 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?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Has the patient demonstrated a clinical benefit from therapy with the requested medication? ***ACTION REQUIRED***: If Yes, attach supporting chart notes or medical record documentation of clinical benefit from therapy with the requested medication.
❒ 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. What is the requested product?

❒ Radicava ORS for oral administration, *Continue to 11*

❒ Radicava for intravenous infusion 30 mg/100 mL per IV bag, *Continue to 12*

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❒ edaravone for intravenous infusion 30 mg/100 mL per IV bag, *Continue to 12*

❒ edaravone for intravenous infusion 60 mg/100 mL per IV bag, *Continue to 13*

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

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

13. 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 CVS Caremark or the benefit plan sponsor.

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

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CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com