BlueCross BlueShield Federal Employee Program

RADICAVA / RADICAVA ORS PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Radicava / Radicava ORS

(edaravone)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Does the patient have a diagnosis of amyotrophic lateral sclerosis (ALS/Lou Gehrig's disease)? ❑Yes ❑No

2. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

a. Has the patient had a baseline evaluation of the condition using ONE of the following scoring tools: ALS Functional Rating Scale-Revised (ALSFRS-R) or Japanese ALS Severity Scale? ***Please select answer below:***

❑**Yes**, ALS Functional Rating Scale-Revised (ALSFRS-R)

i. Does the patient have a score of 2 or greater on each individual item of the scale? ❑Yes ❑No

❑**Yes**, Japanese ALS Severity Scale

i. Does the patient have a grade of 1 or 2? ❑Yes ❑No

❑**No**

b. Does the patient have normal respiratory function defined as a forced vital capacity (FVC) greater than or equal to 80 percent? ❑Yes ❑No

c. Will this medication be used in combination with riluzole (Rilutek)? ❑Yes ❑No*****

If NO, has the patient had an inadequate response to riluzole (Rilutek)? ❑Yes ❑No

d. Is this medication being prescribed or recommended by a neurologist? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

a. Is there documentation of stabilization, slowing of disease progression, or improvement of the condition using ONE of the following scoring tools: ALSFRS-R (ALS Functional Rating Scale-Revised) or Japanese ALS Severity Scale? ❑Yes ❑No