RADICAVA
PRIOR AUTHORIZATION/MEDICAL NECESSITY DETERMINATION
PRESCRIBER FAX FORM

ONLY the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

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PATIENT AND INSURANCE INFORMATION **Today's Date:** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis:
- ☐ Amyotrophic lateral sclerosis (ALS)
- ☐ Other (ICD code and diagnosis): _____

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. Is the patient currently treated with the requested agent? ..... ☐ Yes ☐ No
2. Does the patient have any FDA labeled contraindications to the requested agent? ..... ☐ Yes ☐ No
   If yes, please specify contraindication: _____
   _____
3. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., neurologist) or has the prescriber consulted with a specialist in the area of the patient's diagnosis? ..... ☐ Yes ☐ No
4. Are there medical records showing the patient has an indication supported in compendia (National Comprehensive Cancer Network (NCCN) Compendium™ level of evidence 1, or 2A; American Hospital Formulary Service (AHFS); Truven Micromedex/DrugDex – Class I or IIa recommendation, Clinical Pharmacology or a phase 3 clinical trial OR the prescriber has submitted a clinical study or additional documentation published in a major peer-reviewed medical journal supporting the requested therapeutic use) for the requested agent? **Medical records are required.** ..... ☐ Yes ☐ No
5. Does the requested quantity (dose) exceed the maximum FDA labeled dose for the requested diagnosis? .... ☐ Yes ☐ No
   If no, can the requested quantity (dose) be achieved with a lower quantity of a higher strength that does not exceed the program quantity limit? ..... ☐ Yes ☐ No
   If no, please explain why the requested dose cannot be optimized: _____
   _____

For amyotrophic lateral sclerosis (ALS):

6. Are there medical records showing the patient had the diagnosis of ALS for a duration of 2 years or less? **Medical records are required.** ..... ☐ Yes ☐ No
7. Are there medical records showing the patient has a baseline percent forced vital capacity (FVC%) of 80% or greater? **Medical records are required.** ..... ☐ Yes ☐ No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

8. Are there medical records showing the patient is able to perform most activities of daily living, defined as scores of 2 points or better on each individual item of the ALS Functional Rating Scale – Revised [ALSFRS-R]? **Medical records are required.** ☐ Yes ☐ No
9. Are there medical records showing the patient is currently being treated with riluzole? **Medical records are required.** ☐ Yes ☐ No
   - If no, are there medical records showing has the patient tried and had an inadequate response to riluzole? **Medical records are required.** ☐ Yes ☐ No
     - If no, is there a MedWatch (http://www.fda.gov/media/76299/download) form showing the patient has an intolerance or hypersensitivity to riluzole? **MedWatch form is required.** ☐ Yes ☐ No
       - If no, are there medical records showing the patient has an FDA labeled contraindication to riluzole? **Medical records are required.** ☐ Yes ☐ No

For renewal requests:

10. Are there medical records showing the patient had clinical benefit with the requested medication? **Medical records are required.** ☐ Yes ☐ No
11. Is the patient dependent on invasive ventilation or tracheostomy? ☐ Yes ☐ No

Please fax or mail this form to:
Horizon Blue Cross Blue Shield of New Jersey
c/o Prime Therapeutics LLC, Clinical Review Department
2900 Ames Crossing Road
Eagan, MN 55121

TOLL FREE
Fax: 877.897.8808 Phone: 888.214.1784