

# RADICAVA

## PRIOR AUTHORIZATION REQUEST

### PRESCRIBER FAX FORM

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

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit [www.myprime.com](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermymeds.com](http://covermymeds.com) to begin using this free service.

**What is the priority level of this request?**

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: \_\_\_\_\_

**PATIENT AND INSURANCE INFORMATION**

Date of Service (if differs from 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: <input type="checkbox"/> Amyotrophic lateral sclerosis (ALS) <input type="checkbox"/> Other (ICD code and description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<b>For all requests:</b> 1. Is the patient currently being treated with the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Does the patient have any FDA labeled contraindications to the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify FDA labeled contraindications: _____ _____ 3. Has the patient been treated with the requested agent within the past 90 days (starting on samples is not approvable)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient at risk if therapy is changed?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify risk: _____ _____ 4. 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? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). <b>Please note, documentation may be required:</b> _____ _____ _____	
<b>Please continue to the next page.</b>	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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**For amyotrophic lateral sclerosis (ALS) requests:**

6. Has the patient had a diagnosis of ALS for 2 years or less? .....  Yes  No
7. Does the patient have a baseline percent forced vital capacity (FVC%) or slow vital capacity (SVC) of 80% or greater? .....  Yes  No
8. Is the patient 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 [ALSFRRS-R]? .....  Yes  No
9. Is the patient currently being treated with riluzole? .....  Yes  No  
 If yes, will the patient continue riluzole in combination with the requested agent? .....  Yes  No  
 If no, does the patient have an intolerance, hypersensitivity, or FDA labeled contraindication to riluzole? .....  Yes  No  
 If yes, please explain intolerance/hypersensitivity or specify contraindication: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**For renewal requests:**

10. Has the patient had clinical benefit with the requested agent? .....  Yes  No
11. Is the patient dependent on invasive ventilation or tracheostomy? .....  Yes  No

**Please fax or mail this form to:**  
 Prime Therapeutics LLC  
 Clinical Review Department  
 2900 Ames Crossing Road Suite 200  
 Eagan, MN 55121

**TOLL FREE**

**Phone:** **Fax: 877.243.6930**  
**BCBSIL: 800.285.9426**  
**BCBSMT: 888.723.7443**  
**BCBSNM: 800.544.1378**  
**BCBSOK: 800.991.5643**  
**BCBSTX: 800.289.1525**

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