



Radicava Prior Authorization with Quantity Limit Program Summary

POLICY REVIEW CYCLE

Effective Date

03-01-2026

Date of Origin

POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Radicava ors ; Radicava ors starter kit	edaravone oral susp	105 MG/5ML	M ; N ; O ; Y	N		

POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
Radicava ors	edaravone oral susp	105 MG/5ML	50	mLs	28	DAYS			705102 32201
Radicava ors starter kit	edaravone oral susp	105 MG/5ML	70	mLs	180	DAYS			705102 32101 ; 705102 32102

CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Radicava ors ; Radicava ors starter kit	edaravone oral susp	105 MG/5ML	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Radicava ors	edaravone oral susp	105 MG/5ML	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Radicava ors starter kit	edaravone oral susp	105 MG/5ML	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	<p>Initial Evaluation</p> <p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> ONE of the following: <ol style="list-style-type: none"> The requested agent is eligible for continuation of therapy AND the following: <p style="text-align: center;">Agents Eligible for Continuation of Therapy</p> <p style="text-align: center;">All target agents are eligible for continuation of therapy</p> <ol style="list-style-type: none"> The prescriber states the patient has been treated with the requested agent within the past 90 days AND is at risk if therapy is changed OR

Module	Clinical Criteria for Approval
	<p>B. ALL of the following:</p> <ol style="list-style-type: none"> 1. The patient has a diagnosis of amyotrophic lateral sclerosis (ALS) AND 2. The patient has had the diagnosis of ALS for a duration of 2 years or less AND 3. The patient has a baseline percent forced vital capacity (FVC%) or slow vital capacity (SVC) of 80% or greater AND 4. 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 [ALSFRRS-R] AND 5. ONE of the following: <ol style="list-style-type: none"> A. BOTH of the following: <ol style="list-style-type: none"> 1. The patient is currently being treated with riluzole AND 2. The patient will continue riluzole in combination with the requested agent OR B. The patient has an intolerance, hypersensitivity, or FDA labeled contraindication to riluzole AND 2. The prescriber is a specialist in the area of the patient’s diagnosis (e.g., neurologist), or the prescriber has consulted with a specialist in the area of the patient’s diagnosis AND 3. The patient does NOT have any FDA labeled contraindications to the requested agent <p>Length of Approval:</p> <p>BCBSOK: 36 months BCBSIL and BCBSMT: 12 months ALL other plans: 6 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p> <p>The requested agent will also be approved when the following are met:</p> <ol style="list-style-type: none"> 1. The member resides in Ohio AND 2. The plan is Fully Insured or HIM Shop (SG) AND BOTH of the following: <ol style="list-style-type: none"> A. The patient does NOT have any FDA labeled contraindications to the requested agent AND B. ONE of the following: <ol style="list-style-type: none"> 1. The patient has another FDA labeled indication for the requested agent and route of administration OR 2. The patient has another indication that is supported in compendia for the requested agent and route of administration OR 3. The prescriber has submitted TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] supporting the proposed use(s) as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required] <p>Non-oncology compendia allowed: DrugDex level 1, 2A or 2B, AHFS-DI (narrative text must be supportive)</p> <p>Oncology compendia allowed: NCCN 1 or 2A, AHFS-DI (narrative text must be supportive), DrugDex level 1, 2A, or 2B, or Clinical Pharmacology (narrative text must be supportive), Lexi-Drugs evidence level A, peer-reviewed medical literature</p> <p>Length of Approval:</p>

Module	Clinical Criteria for Approval
	<p>BCBSOK: 36 months ALL other plans:12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria</p> <p>Renewal Evaluation</p> <p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. The patient has been previously approved for the requested agent through the plan's Prior Authorization process [Note: patients not previously approved for the requested agent will require initial evaluation review] AND 2. The patient has had clinical benefit with the requested agent AND 3. The patient is NOT dependent on invasive ventilation or tracheostomy AND 4. The prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist), or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND 5. The patient does NOT have any FDA labeled contraindications to the requested agent <p>Length of Approval:</p> <p>BCBSOK: 36 months ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p>

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	<p>Quantity Limit for the Target Agent(s) will be approved when ONE of the following is met:</p> <ol style="list-style-type: none"> 1. The requested quantity (dose) does NOT exceed the program quantity limit OR 2. The requested quantity (dose) exceeds the program quantity limit AND ONE of the following: <ol style="list-style-type: none"> A. BOTH of the following: <ol style="list-style-type: none"> 1. The requested agent does NOT have a maximum FDA labeled dose for the requested indication AND 2. There is support for therapy with a higher dose for the requested indication OR B. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication OR C. BOTH of the following: <ol style="list-style-type: none"> 1. The requested quantity (dose) exceeds the maximum FDA labeled dose for the requested indication AND 2. There is support for therapy with a higher dose for the requested indication <p>Length of Approval:</p> <p>BCBSIL: 12 months</p> <p>All other plans: Initial: 6 months; Renewal: 12 months</p> <p>NOTE: If approving initial loading dose for the intravenous infusion, approve the loading dose per FDA labeling for 28 days, followed by maintenance dosing for the remainder of the length of approval.</p>

