Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Radicava
(edaravone)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Radicava

Dose and Quantity: Duration of therapy: J-Code:

Frequency of administration: ICD10:

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples, please choose "new start of therapy". ☐ new start of therapy ☐ continued therapy

(if continued therapy) Has your patient had beneficial clinical response to the requested drug? ☐ Yes ☐ No
(if continued therapy) Is your patient dependent on invasive ventilation? ☐ Yes ☐ No
Please provide clinical support for the continued use of Radicava:

Where will this medication be obtained?
☐ Prescriber's office stock (billing on a medical claim form) ☐ Home Health / Home Infusion vendor
☐ Other (please specify):

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting*
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Is this infusion occurring in a facility affiliated with hospital outpatient setting? ☐ Yes ☐ No

If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Clinical Information:

*****This drug requires supportive documentation (chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.*****

Does your patient have a documented diagnosis of amyotrophic lateral sclerosis (ALS)? ☐ Yes ☐ No (please specify)

Has your patient's diagnosis been documented as “definite” or “probable” amyotrophic lateral sclerosis (ALS) based on El Escorial – Revised (Airlie House) criteria? ☐ Yes ☐ No

Was this drug prescribed by, or in consultation with, a neurologist, a neuromuscular disease specialist, or a physician specializing in the treatment of Amyotrophic Lateral Sclerosis (ALS)? ☐ Yes ☐ No

Prior to starting Radicava, how long has/had it been since disease onset?

☐ 2 years or less ☐ over 2 years ☐ unknown

Prior to starting Radicava, does/did your patient retain most activities of daily living (defined as a score of 2 points or better on each item of the ALS Functional Rating Scale – Revised [ALSFRS-R] [i.e., a minimum score of 24]? ☐ Yes ☐ No

Prior to starting Radicava, does/did your patient have normal respiratory function (defined as percent-predicted forced vital capacity values of [% FVC] of at least 80%)? ☐ Yes ☐ No

Additional Information: *(including pertinent patient history, alternatives tried with date(s) taken and documented results, etc):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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