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:		* Patient Name:		
Office Contact Person:			* Cigna ID:	* Date of Birth:	
Office Phone:			* Patient Street Address:		
Office Fax:			City	State	Zip
Office Street Address:			Patient Phone:		
City	State	Zip			

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 30 mg / 100 ml
☐ edaravone (generic Radicava) 30 mg / 100 ml

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

Frequency of administration: ICD10:

Is this initial therapy or is the patient currently receiving Radicava IV (edaravone) or Radicava ORS?

☐ Initial therapy
☐ Currently receiving Radicava IV or Radicava ORS

(if currently receiving) According to the prescriber, does the patient continue to benefit from therapy? ☐ Yes ☐ No

(if no) Please provide support for continued use.

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

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

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options 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.*****

What is the patient's diagnosis or reason for treatment?

☐ Amyotrophic Lateral Sclerosis (ALS)
☐ Aneurysmal Subarachnoid Hemorrhage
☐ Myocardial Infarction (MI)
☐ Radiation-Induced Brain Injury
☐ Retinal Vein Occlusion
☐ Sensorineural Hearing Loss
☐ Stroke
☐ Other (please specify): _____

(if initial therapy) Is documentation being provided that the patient has a "definite" or "probable" diagnosis of amyotrophic lateral sclerosis (ALS) based on the application of the El Escorial or the revised Airlie House diagnostic criteria? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. ☐ Yes ☐ No

(if initial therapy) Does your patient retain most or all 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])? ☐ Yes ☐ No

(if initial therapy) Does your patient have normal respiratory function (defined as a percent-predicted forced vital capacity (FVC) of at least 80%)? ☐ Yes ☐ No

(if initial therapy) How long has it been since the patient was diagnosed with ALS?
☐ 2 years or less
☐ over 2 years
☐ unknown

(if initial therapy) Has your patient received (or is your patient currently receiving) riluzole tablets; Tiglutik (riluzole oral suspension); or Exservan (riluzole oral film)? ☐ Yes ☐ No

Was this medication 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

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.

v050125