



Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Radicava ORS (edaravone) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 3 months; Continuation- 6 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Radicava ORS (edaravone)**. Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours (fax: 1-866-331-2104). If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: [Pharmacy | Community Provider Portal | Kaiser Permanente](#)

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____
Prescriber Address: _____
Prescriber Phone #: _____ Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____
Pharmacy Phone #: _____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____
Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
 Initial therapy Continuing therapy, state start date: _____

2. Indicate the patient’s diagnosis for the requested medication: _____

Clinical Criteria:

- 1. Prescriber is a Neurologist,
 No Yes

- 2. **AND** ALS Functional Rating Scale – Revised (ALSFERS-R) score of 2 points or better on each of the 12 items within past 2 months,
 No Yes

- 3. **AND** clinical ALS diagnosed by a neurologist with duration of 2 years or less from onset for first symptom,
 No Yes

- 4. **AND** forced vital capacity (%FVC) \geq 80% within past 2 months,
 No Yes

- 5. **AND** patient has had a trial of riluzole
 No Yes

For continuation of therapy, please respond to additional questions below:

- 1. Documentation of positive clinical response,
 No Yes

- 2. **AND** specialist follow-up occurred since last review,
 No Yes

- 3. **AND** patient does not have any of the following:
 - %FVC \leq 50% and blood gas PaCO₂ > 45 mmHg
 - Significant clinical decline based on ALSFRS-R and/or % FVC status
 - Non-adherence to follow-up assessments
 - Patient is requiring hospice care No Yes

6 – Prescriber Sign-Off

Additional Information –

- 1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
- 2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	Date:
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