Prior Authorization Request Form for
edaravone **(Radicava ORS)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the patient greater than or equal to 18 year of age?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Is the requested medication prescribed by a neurologist?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. What is the indication or diagnosis?	☐ Amyotrophic lateral sclerosis - Proceed to question **4** ☐ Other **– STOP Coverage not approved**	
4. Is the disease duration less than or equal 2 years?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Does the patient have a score greater than or equal to 2 points for each item of ALS Functional Rating Scale–Revised (ALSFRS-R)?	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved

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6. Does the patient have preserved respiratory function (forced vital capacity greater than or equal to 80%)?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.**
Please sign and date:

_____ _____
Prescriber Signature Date

[27 July 2022]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#: