SecurityHealth Plan℠
Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 711

Radicava® (Edaravone)

Prior Authorization Request

Date _____

Member information		
Member name (print)	SMID	Date of birth (month/day/year)
Provider information		
Provider name (print)	Telephone number	Fax number
Place of service: ☐ Ambulatory Surgery Center ☐ Hospital outpatient ☐ Hospital inpatient ☐ Provider's office ☐ Other _____		
Facility where services will be provided (include address if the provider provides services at more than one practice location)		
Contact person name (print)	Telephone number	Fax number
Procedure information		
Scheduled date of service (month/day/year)	Requested service/procedure	Procedure code(s)
Diagnosis	Diagnosis code(s)	

Answer all of the following questions.

Does the intended dose agree with the below dosing ☐ Yes ☐ No
Initial dosing: 60 mg for 14 days, followed by 14 days off
Maintenance dosing: 60 mg for 10 of 14 days, followed by 14 days off

Initial request ☐ Yes ☐ No

- Is the patient 18 years of age or older ☐ Yes ☐ No
- Patient has a diagnosis of clinically definite or probable ALS based on El Escorial revised criteria or Awaji criteria. ☐ Yes ☐ No
- Patient has a disease duration of 2 years or less ☐ Yes ☐ No
- Patient has a percent-predicted forced vital capacity (% FVC) ≥ 80% ☐ Yes ☐ No
- Patient has baseline documentation of retained functionality for most activities of daily living (i.e. score of 2 points or better on each individual item of the ALS Functional Rating Scale – Revised [ALSFRS-R]) ☐ Yes ☐ No

Renewal request ☐ Yes ☐ No

- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include the following: hypersensitivity reactions, sulfite allergic reactions, confusion, etc. ☐ Yes ☐ No
- Patient has responded to therapy compared to pretreatment baseline with disease stability or mild progression indicating a slowing of decline on the ALSFRS-R (patient ha snot experienced rapid disease progression while on therapy) ☐ Yes ☐ No
- Patient does not have a cumulative score on the ALSFRS-R of ≤ 3 ☐ Yes ☐ No

By signing this form, the provider attests that the above information is accurate and documented in the medical record. Security Health Plan may, at its discretion, request medical records to make a final coverage determination.

_____ _____

Provider signature Date

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to:	Security Health Plan Health Services Department PO Box 8000 Marshfield, WI 54449-8000 Fax 715-221-6616	**Marshfield Clinic providers route to:** Health Services Department Routing location, SHP

If you have any questions, please contact Customer Service at 1-800-548-1224

