

RADICAVA (Edaravone) ORDER FORM

REFERRAL TYPE

New Referral
 Order Renewal
 Restart
 Frequency Change
 Dosage Change

PREFERRED LOCATION

2730 University Blvd. West | Suite 714
Wheaton, MD 20902

14995 Shady Grove Road | Suite 250
Rockville, MD 20850

5454 Wisconsin Avenue | Suite 600
Chevy Chase, MD 20815

18111 Prince Philip Drive | Suite 323
Olney, MD 20832

71 Thomas Johnson Drive
Frederick, MD 21702

2021 K Street, NW | Suite 300
Washington, DC 20006

3027 Javier Road | Suite 2
Fairfax, VA 22031

PATIENT INFORMATION

Name: _____ DOB: _____ Email: _____

Address: _____ Weight: _____ KG LBS Phone: _____

REFERRING PHYSICIAN INFORMATION

Name: _____ NPI: _____

Office Contact Name: _____ Phone: _____ Fax: _____

Address: _____

RADICAVA ORDER

We do not accept off-label diagnoses, dosages, or frequencies.

Dosing/Frequency:

- Initial Dose: Once daily 60 mg/200mL, 60-minute IV infusion for 14 consecutive days, followed by cessation by 14 days
 Maintenance Dose: Once daily 60 mg/200 mL, 60-minute IV infusion for any 10 of 14 days, followed by cessation for 14 days

Diagnosis:

- G12.21—Amyotrophic lateral sclerosis

Ambulate: Independent With Assistance Wheelchair Stretcher

Special Instructions: _____

Physicians Signature: _____ Date: _____ *(Order is Valid for One Year)*

REQUIRED DOCUMENTATION

Please fax the following documents and records:

- Patient Demographics
- Two most recent office notes (Supporting the DX and treatment ordered)
- Most recent ALS functional rating scale score
- Copy of the patient's insurance card(s) – front and back
- Medication History
- For continuation of treatment, include the last infusion note

We will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.