

### RADICAVA (Edaravone) ORDER FORM

REFERRAL TYPE				
<input type="checkbox"/> New Referral	<input type="checkbox"/> Order Renewal	<input type="checkbox"/> Restart	<input type="checkbox"/> Frequency Change	<input type="checkbox"/> Dosage Change
PREFERRED LOCATION				
<input type="checkbox"/> 2730 University Blvd. West   Suite 714 Wheaton, MD 20902	<input type="checkbox"/> 14995 Shady Grove Road   Suite 250 Rockville, MD 20850	<input type="checkbox"/> 5454 Wisconsin Avenue   Suite 600 Chevy Chase, MD 20815		
<input type="checkbox"/> 18111 Prince Philip Drive   Suite 323 Olney, MD 20832	<input type="checkbox"/> 161 Thomas Johnson Drive   Suite 250 Frederick, MD 21702	<input type="checkbox"/> 2021 K Street, NW   Suite 300 Washington, DC 20006		
	<input type="checkbox"/> 8270 Willow Oaks Corporate Drive   Suite 150 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				
<b><i>WE DO NOT ACCEPT OFF-LABEL DIAGNOSIS, DOSE AND FREQUENCY</i></b>				
<b>Dosing/Frequency:</b>				
<input type="checkbox"/> Initial Dose: Once daily 60 mg/200mL, 60-minute IV infusion for 14 consecutive days, followed by cessation by 14 days				
<input type="checkbox"/> Maintenance Dose: Once daily 60 mg/200 mL, 60-minute IV infusion for any 10 of 14 days, followed by cessation for 14 days				
<b>Diagnosis:</b>				
<input type="checkbox"/> G12.21—Amyotrophic lateral sclerosis				
<b>Ambulate:</b> <input type="checkbox"/> Independent <input type="checkbox"/> With Assistance <input type="checkbox"/> Wheelchair <input type="checkbox"/> Stretcher				
Special Instructions:				
Physicians Signature:			Date: <span style="float: right;"><i>(Order is Valid for One Year)</i></span>	
REQUIRED DOCUMENTATION				
<b>Please fax the following documents and records:</b>				
● Patient Demographics		● Copy of the patient's insurance card(s) – front and back		
● Two most recent office notes (Supporting the DX and treatment ordered)		● Medication History		
● Most recent ALS functional rating scale score		● For continuation of treatment, include the last infusion note		
<b><i>We will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.</i></b>				