Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Radicava
(edaravone)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:		* Patient Name:		
Office Contact Person:			* Cigna ID:	* Date of Birth:	
Office Phone:			* Patient Street Address:		
Office Fax:			City	State	Zip
Office Street Address:			Patient Phone:		
City	State	Zip			

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Radicava

Dose and Quantity: Duration of therapy: J-Code:

Frequency of administration: ICD10:

Is this initial therapy or is the patient currently receiving Radicava IV or Radicava ORS?

☐ Initial therapy
☐ Currently receiving Radicava IV or Radicava ORS

(if currently receiving) Has the prescriber confirmed that the patient continues to benefit from therapy? ☐ Yes ☐ No

(if no) Please provide support for continued use.

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Clinical Information:

*****This drug requires supportive documentation (chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.*****

What is the patient's diagnosis or reason for treatment?

☐ Amyotrophic Lateral Sclerosis (ALS)
☐ Aneurysmal Subarachnoid Hemorrhage
☐ Myocardial Infarction (MI)
☐ Radiation-Induced Brain Injury
☐ Retinal Vein Occlusion
☐ Sensorineural Hearing Loss
☐ Stroke
☐ Other (please specify): _____

(if initial therapy) Has your patient's diagnosis been documented as "definite" or "probable" amyotrophic lateral sclerosis (ALS) based on the application of the El Escorial or the revised Airlie House diagnostic criteria? ☐ Yes ☐ No

(if initial therapy) Does your patient retain most or all activities of daily living (defined as a score of 2 points or better on each item of the ALS Functional Rating Scale - Revised [ALSFRS-R])? ☐ Yes ☐ No

(if initial therapy) Does your patient have normal respiratory function (defined as a percent-predicted forced vital capacity (FVC) of at least 80%)? ☐ Yes ☐ No

(if initial therapy) How long has it been since the patient was diagnosed with ALS?
☐ 2 years or less
☐ over 2 years
☐ unknown

(if initial therapy) Has your patient received (or is your patient currently receiving) riluzole tablets; Tiglutik (riluzole oral suspension); or Exservan (riluzole oral film)? ☐ Yes ☐ No

Was this medication prescribed by, or in consultation with, a neurologist, a neuromuscular disease specialist, or a physician specializing in the treatment of Amyotrophic Lateral Sclerosis (ALS)? ☐ Yes ☐ No

Additional Information: *(including pertinent patient history, alternatives tried with date(s) taken and documented results, etc):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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