HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Radicava Oral Solution - Non-PDL

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is this a renewal request? If no, go to question 4.

☐ Yes ☐ No

Q2. Does the previous approval criteria still stand?

☐ Yes ☐ No

Q3. Does the patient have documented clinical benefit from Radicava ORS? Clinical benefit may include slowing of decline, stabilization of symptoms, prescriber discretion, etc.?

☐ Yes ☐ No

Q4. Does patient have a diagnosis of amyotrophic lateral sclerosis (ALS)?

☐ Yes ☐ No

Q5. Does the patient have documentation of most recent ALS Functional Rating Scale-Revised (ALSFRS-R) scores ≥ 2 in all items of the ALSFRS-R criteria at the start of treatment?

☐ Yes ☐ No

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Member Name:	Prescriber Name:

Q6. Does the patient have documentation of a % forced vital capacity (%FVC) ≥ 80% at the start of treatment?

☐ Yes ☐ No

Q7. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q8. Is the patient or caregiver capable of administering Radicava ORS (edaravone) for ALS is in accordance with the United States Food and Drug Administration approved labeling?

☐ Yes ☐ No

Q9. Is the patient dependent on invasive ventilation or tracheostomy?

☐ Yes ☐ No

Q10. Is the prescriber a neurologist or in consultation with a neurologist?

☐ Yes ☐ No

Q11. Does the patient have any contraindications to Radicava (edaravone)?

☐ Yes ☐ No

Q12. Does the patient have a serious or anaphylactic reaction to sulfites?

☐ Yes ☐ No

Q13. Additional Information:

_____ _____

Prescriber Signature Date

v2025