# Radicava

## Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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**Patient's Name:** ______________________________ **Date**: _________________________________
**Patient's ID:** ______________________________ **Patient's Date of Birth:** ________________
**Physician's Name:** ____________________________________________________________________
**Specialty:** __________________________________ **NPI#:** _________________________________
**Physician Office Telephone:** __________________ **Physician Office Fax:** ____________________

**<u>Referring</u> Provider Info:** ❑ **Same as Requesting Provider**
**Name:** __________________________________________ **NPI#:** _______________________________
**Fax:** _________________________ **Phone:** ______________________

**<u>Rendering</u> Provider Info:** ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
**Name:** __________________________________________ **NPI#:** _______________________________
**Fax:** _________________________ **Phone:** ______________________

***Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.***

**<u>Required Demographic Information:</u>**

*Patient Weight:* __________________________*kg*

*Patient Height:* __________________________*cm*

**Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720**

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**Site of Service Questions (SOS):**

A. Where will this drug be administered?
❑ Ambulatory surgical, *skip to Clinical Questions*
❑ Home infusion, *skip to Clinical Questions*
❑ Off-campus Outpatient Hospital
❑ On-campus Outpatient Hospital
❑ Physician office, *skip to Clinical Questions*
❑ Pharmacy, *skip to Clinical Questions*

B. Is this request to continue previously established treatment with the requested medication?
❑ Yes - This is a continuation of an existing treatment.
❑ No - This is a new therapy request (patient has not received requested medication in the last 6 months). *skip to Clinical Criteria Questions*

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, or other pre-medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: Attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment? ***ACTION REQUIRED: Attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: Attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: Attach supporting clinical documentation.*** ❑ Yes ❑ No

**Criteria Questions:**

1. What is the diagnosis?
❑ Amyotrophic lateral sclerosis (ALS)
❑ Other ______________________________________________

2. What is the ICD-10 code? ____________

3. Is the requested medication being prescribed by or in consultation with a neurologist, neuromuscular specialist, or physician specializing in the treatment of amyotrophic lateral sclerosis (ALS)? ❑ Yes ❑ No

4. Is this request for continuation of therapy with the requested medication? *If Yes, skip to #8* ❑ Yes ❑ No

5. Is the diagnosis classified as definite or probable ALS? ***ACTION REQUIRED: If Yes, attach clinical documentation (e.g., chart notes or medical records) supporting the diagnosis or possible diagnosis of amyotrophic lateral sclerosis.*** ❑ Yes ❑ No

6. Does the patient have scores of at least 2 points on all 12 areas of the revised ALS Functional Rating Scale (ALSFRS-R)? ***ACTION REQUIRED: If Yes, attach clinical documentation supporting the ALS Functional Rating Scale results.*** ❑ Yes ❑ No

7. Does the patient require continuous use of ventilatory support during the day and night (noninvasive or invasive)?
❑ Yes ❑ No *If No, skip to #11*

8. Is the diagnosis classified as definite or probable ALS? ❑ Yes ❑ No

9. Is treatment with the requested medication providing a clinical benefit? ***ACTION REQUIRED: If Yes, attach clinical documentation (e.g., chart notes/medical records) supporting the patient is receiving a clinical benefit from use of the requested drug.*** ❑ Yes ❑ No


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**CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062**
**Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com**

10. Does the patient require invasive ventilatory support (eg,e.g., tracheostomy and mechanical ventilation)?
    ❑ Yes ❑ No
11. What is the requested formulation?
    ❑ Radicava ORS for oral administration
    ❑ Radicava for intravenous infusion
12. Is the patient currently receiving the requested medication? ❑ Yes ❑ No

***I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.***

X_______________________________________________

**Prescriber or Authorized Signature** **Date (mm/dd/yy)**

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