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## RADICAVA PRIOR AUTHORIZATION REQUEST FORM

This form **MUST BE** submitted with medical records to support services

Date:		
<b>RECEIPIENT INFORMATION</b>		
Medicaid ID:	Date of Birth:	Sex:    M        F
Last Name:		First Name:
<b>GENERAL INFORMATION</b>		
First Date of Service:	Last Date of Service:	
Primary Diagnosis Code:	HCPC Code:	
Drug Name:	Dose & Frequency:	
Hospitalizations/Treatments/Medications Used in the last 6 months:		
<b>POINT OF CONTACT</b>		
Name and Title:		
Email:	Phone:	Fax:
<small><i>Note: The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA. The determination notice will be sent to the listed point of contact.</i></small>		
<b>REFERRING PROVIDER INFORMATION</b>		
Name:		
NPI #:	Taxonomy:	
Phone:	Fax:	
<b>SERVICING PROVIDER INFORMATION</b>		
Name:		
Address:		
NPI #:	Taxonomy:	
Phone:	Fax:	

<b>CRITERIA</b>		
<b>Medical records to support use of product are submitted</b>		
<b>Initial Therapy (check one)</b>	<b>Yes</b>	<b>No</b>
	Therapy is prescribed by or in consult with a neurologist	
	Individual has a documented diagnosis of ALS	
	Individual has a Japanese ALS Severity Scale grade of 1 or 2	
	Onset of ALS has been <2 years since time of therapy initiation	
	Baseline ALS Functional Rating Scale-Revised (ALSFRS-R) is provided and indicates a score of ≥2 in all areas	
	Documentation is provided indicating forced vital capacity (FVC) >80%	
	Individual is ≥18 years of age	
<b>Continuation of Therapy (check one)</b>	<b>Yes</b>	<b>No</b>
	Individual continues to meet all initial criteria	
	Japanese ALS Severity Scale grade documented at time of therapy renewal	
	ALS Functional Rating Scale-Revised (ALSFRS-R) scores documented at time of renewal	
<b>PHYSICIAN SIGNATURE – PROVIDER ONLY</b>		
This form <u>must be</u> signed by a provider		
	I certify that the information given in this form is a true and accurate medical indication for the required product	
<b>Name &amp; Title (Printed):</b>		<b>Specialty:</b>
<b>Signature:</b>		