



**MEDICAID / CHIP**  
**PHARMACY PRIOR AUTHORIZATION REQUEST FORM**

**Radicava Oral Solution - Non-PDL**

Phone: 866-841-7659

Fax back to: 866-240-3712

Jefferson Health 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:	
Member ID Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Phone Number:	NPI:	PA PROMISe ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):	
Drug Name:	Strength:	
Quantity:	Refills:	
Directions:		
Diagnosis Code:	Diagnosis:	

*Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..*

**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  $\geq 2$  in all items of the ALSFRS-R criteria at the start of treatment?

Yes

No



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Q6. Does the patient have documentation of a % forced vital capacity (%FVC)  $\geq$  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 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

v2026-06