Edaravone (Radicava™) Referral Form

Phone 405.548.4848 **Toll Free** 888.848.4588 **Fax** 405.418.4442

PATIENT INFORMATION

Patient Name:		Date of Referral:	
Address:		SSN:	Gender:
City, State, Zip:		DOB:	Age:
Caregiver Name (if other):		Relationship:	Phone:
Emergency Contact:		Relationship:	Phone:
Primary Insurance Subscriber:		Primary Language:	
Policy #:	Group #:	Phone #:	
Insurance Phone:		Work Phone #:	

PRIMARY DIAGNOSIS

☐ G12.21 - Amyotrophic lateral sclerosis

☐ Other - Please indicate ICD10-CM code & description:_____

_____

Date of diagnosis or years with disease:_____

CURRENT MEDICATIONS

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY

Allergies: ☐ NKDA

☐ Yes, listed:_____

_____

Ht:_____ ☐ in ☐ cm

Wt:_____ ☐ lbs ☐ kg

Date Taken:_____

EDARAVONE (RADICAVA™) PRESCRIPTION AND ORDERS

Is this the first dose? ☐ Yes ☐ No ☐ Start ASAP

If no, first dose given? _____ ☐ First/next dose due_____

Code Status:_____

Initial Treatment Cycle:

☐ 60mg IV over 60 minutes daily for 14 days followed by a 14 day drug-free period x 1 cycle

Subsequent Treatment Cycles:

☐ 60mg IV over 60 minutes daily for 10 days within a 14 day period, followed by a 14 day drug-free period

Repeat every 28 days x_____ cycles

Lab and Other Orders: ☐ _____

Adverse and Anaphylactic Reactions will be treated per OptionOne protocol.

Catheter Maintenance, Supply and Nursing Orders:
• OptionOne to provide IV catheter maintenance therapy per protocol • Flush intravenous access device per OptionOne protocol • Provide all supplies necessary to administer therapy • Skilled nurse to train patient/caregiver to self-administer medication, maintain PIV and central IV access, and how to monitor and treat ADRs, and administer medications as ordered

Access Device
☐ Peripheral
☐ Peripheral-Midline
☐ PICC & Central Tunneled & Non-Tunneled
☐ Implanted Port

Please attach and fax
1. Insurance card(s) and demographic information
2. Recent clinical assessment note or H&P
3. Current medication list

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.	***Signature:***
	Date:

PHYSICIAN INFORMATION

Name:		Hospital/Clinic:	
Address:		Office Contact:	
City, State, Zip:		Phone:	Fax:
NPI:	UPIN:	License #:	