

EDARAVONE (RADICAVA®) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to: **(888) 822-5060**



Patient Name:		Date of Birth:		
Address:				
Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg

Clinical Information

Primary Diagnosis Description: Amyotrophic lateral sclerosis (ALS) ICD-10 Code: G12.21

Edaravone (Radicava®) Prescription

Edaravone (Radicava®) 30 mg/100 mLs bags refill as directed x 1 year

- Initial Cycle:** Infuse 60 mg IV over 60 minutes daily for 14 days followed by a 14-day drug-free period x 1 cycle.
- Maintenance Cycles:** Infuse 60 mg IV over 60 minutes daily for 10 days within a 14 day period followed by a 14-day drug-free period. Repeat maintenance cycle every 28 days.

Ancillary Orders

Anaphylaxis Kit

If this is a 1st dose, would you like Option Care to provide an anaphylaxis kit with the 1st dose?

- Yes – please complete Anaphylaxis Physician Order (FR-PC-036) No

Medication Orders

- Lidocaine/prilocaine 2.5%/2.5% (or equivalent) anesthetic cream 30 gm – apply topically 30 min prior to venipuncture or port access as needed for numbing.
- Other: _____

IV Flush Orders

- Peripheral: NS 2 to 3 mL pre-/post-use. Heparin (10 unit/mL) 1 to 3 mL post-use. For maintenance, heparin (10 unit/mL) every 24 hr.
- Peripheral-Midline: NS 3 to 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw. Heparin (100 unit/mL) 3 mL post-use. For maintenance, flush with heparin (100 unit/mL) 3 mL every 24 hr.
- PICC and Central Tunneled/Non-Tunneled: NS 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw. Heparin (10 unit/mL) 5 mL or (100 unit/mL) 3 mL post-use. For maintenance, flush with heparin (10 unit/mL) 5 mL or (100 unit/mL) 3 mL every 24 hr.
- Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Skilled nurse to teach patient and/or caregiver to administer doses intravenously. Refill above ancillary orders as directed x 1 year.

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

Prescriber Signature: _____ Date: _____

Prescriber Information

Prescriber Name:	Phone:	Fax:
Address:	NPI:	
City, State:	Zip:	Office Contact:

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