ARJ Infusion SERVICES

Specialty Pharmacy and Nursing

FAX completed form to ARJ 877-451-8955
Intake Specialist 866-451-8804
referral@arjinfusion.com
arjinfusion.com/referrals

Radicava (edaravone) I Order Form

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

1. For new patients, please submit with form:

☒ Copy of insurance card ☒ Patient demographics ☒ History & physical ☒ Pertinent lab results

2. Patient Information

☐Male ☐Female Height: _____ in/cm Weight: _____ lbs/kg Allergies: _____ (Note: Radicava contains sulfite)

Is this the first dose? ☐Yes ☐No, date of last infusion: _____ Line type: ☐ PIV ☐PICC ☐Port ☐Other

***JourneyMate Support Program*™ PATIENT ID** (existing patients only): _____

3. Diagnosis and Clinical Information

Primary diagnosis information: ☐ ALS ☐ Other: _____ ICD-10 (required): _____

4. Prescription Information

Medication	☒ **Radicava** (edaravone)
Dosing / Frequency	☒Initial cycle: 60 mg/200 mL IV once daily x 14 days, followed by a 14-day drug-free period ☒Subsequent cycles: 60 mg/200 mL daily x any 10 days within a 14-day period, followed by a 14-day drug free period ☐Initial cycle completed, next maintenance dose due: _____
Administration	☒Infuse per manufacturer guidelines. Administer as two consecutive 30 mg infusion bags (60 mg/200 mL total) over 60 minutes (infusion rate: ~1 **mg**/minute [3.33 **mL**/minute]) ☒ May infuse in patient home unless otherwise noted: _____
Quantity / Refills	Initial cycle: Dispense 14-day supply Refills: Dispense 10-day supply for each cycle x 12 months unless otherwise specified: _____

5. Additional Orders

☒ RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per ARJ Policy and Procedure

☒ RN to instruct patient to hydrate pre/post infusion. RN to instruct patient to take acetaminophen 325-650 mg PO every 4-6 hours for 24-48 hours as needed to prevent/treat post infusion headache

6. Adverse Reaction Orders

With any signs or symptoms consistent with a hypersensitivity reaction the following orders will be promptly followed, and the physician will be notified:

☒ **STOP** infusion. Infuse D5W or NS at 20 mL/hr to keep line open, may increase to 100-250 mL/hr for hydration. May give the following if stopping the infusion does not resolve symptoms:

☒ Diphenhydramine 50 mg IV diluted in D5W or NS 50-100 mL, infused over 10-15 min **OR** 50 mg/10 mL NS IV push over 2-3 min

☒ Epinephrine (1:1000) by weight for use IM or SQ in anaphylactic reaction. May repeat one time. EMS/911 will be called if used

7. Prescriber Information

Prescriber Name: _____ Office Contact: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

License No.: _____ DEA No.: _____ NPI: _____

_____ _____ _____ _____

Physician Signature (Substitution Permitted) **Date** **Physician Signature (Dispense as Written)** **Date**

By signing I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment. ARJ Infusion Services has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.