



### Radicava (edaravone) I Order Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**1. For new patients, please submit with form:**

<input checked="" type="checkbox"/> Copy of insurance card	<input checked="" type="checkbox"/> Patient demographics	<input checked="" type="checkbox"/> History & physical	<input checked="" type="checkbox"/> Pertinent lab results
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**2. Patient Information**

<input type="checkbox"/> Male <input type="checkbox"/> Female Height: _____ in/cm Weight: _____ lbs/kg Allergies: _____ (Note: Radicava contains sulfite) Is this the first dose? <input type="checkbox"/> Yes <input type="checkbox"/> No, date of last infusion: _____ Line type: <input type="checkbox"/> PIV <input type="checkbox"/> PICC <input type="checkbox"/> Port <input type="checkbox"/> Other JourneyMate Support Program™ PATIENT ID (existing patients only): _____
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**3. Diagnosis and Clinical Information**

Primary diagnosis information: <input type="checkbox"/> ALS <input type="checkbox"/> Other: _____ ICD-10 (required): _____
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**4. Prescription Information**

<b>Medication</b>	<input checked="" type="checkbox"/> Radicava (edaravone)
<b>Dosing / Frequency</b>	<input checked="" type="checkbox"/> Initial cycle: 60 mg/200 mL IV once daily x 14 days, followed by a 14-day drug-free period <input checked="" type="checkbox"/> Subsequent cycles: 60 mg/200 mL daily x any 10 days within a 14-day period, followed by a 14-day drug free period <input type="checkbox"/> Initial cycle completed, next maintenance dose due: _____
<b>Administration</b>	<input checked="" type="checkbox"/> 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]) <input checked="" type="checkbox"/> May infuse in patient home unless otherwise noted: _____
<b>Quantity / Refills</b>	Initial cycle: Dispense 14-day supply Refills: Dispense 10-day supply for each cycle x 12 months unless otherwise specified: _____

**5. Additional Orders**

<input checked="" type="checkbox"/> RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per ARJ Policy and Procedure <input checked="" type="checkbox"/> 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
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**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: <input checked="" type="checkbox"/> <b>STOP</b> 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: <input checked="" type="checkbox"/> Diphenhydramine 50 mg IV diluted in D5W or NS 50-100 mL, infused over 10-15 min <b>OR</b> 50 mg/10 mL NS IV push over 2-3 min <input checked="" type="checkbox"/> Epinephrine (1:1000) by weight for use IM or SQ in anaphylactic reaction. May repeat one time. EMS/911 will be called if used
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**7. Prescriber Information**

Prescriber Name: _____	Office Contact: _____
Address: _____	City: _____ State: _____ Zip: _____
Phone: _____	Fax: _____
License No.: _____	DEA No.: _____ NPI: _____
_____	_____
<b>Physician Signature (Substitution Permitted)</b>	<b>Date</b>
_____	_____
<b>Physician Signature (Dispense as Written)</b>	<b>Date</b>
_____	_____

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.

Confidential Health Information: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization and under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law. Important Warning: This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any discrimination, distribution, or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately.