PARAGON
HOME INFUSION

RADICAVA (EDARAVONE) INFUSION ORDERS

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S), FRONT AND BACK

MEDICAL INFORMATION

Diagnosis: ☐ Amyotrophic Lateral Sclerosis (ALS) ICD-10 Code:_____

☐ Other: _____ ICD-10 Code:_____

Patient Weight: _____ lbs.

Allergies: _____

These documents are REQUIRED at time of referral, and are necessary to obtain authorization:

- ☐ Searchlight Forms
- ☐ ALSFRS
- ☐ PFTs
- ☐ Baseline EMG
- ☐ H & P with diagnosis date

RADICAVA ORDERS

☐ **Initial Treatment Cycle**: 60mg IV daily for 14 days followed by 14-day drug free periods.

☐ **Subsequent Dosing**: 60mg IV daily for 10 days out of 14-day periods, followed by 14 day drug free periods x 1 year.

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Date: _____

Physician Name: _____

Phone: _____ Fax: _____ Contact Person: _____

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