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: ____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: ____

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.

Additional Orders/Comments:

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: ______________________

INFUSION CENTER LOCATION

☐ Arlington	☐ Austin	☐ Dallas	☐ Houston	☐ Knoxville	☐ North Hills	☐ Plano	☐ Round Rock	☐ San Antonio	☐ Stone Oak
P: 817.200.2530	P: 512.261.4800	P: 972.408.2777	P: 713.860.1755	P: 865-299-7525	P: 817.284.2700	P: 469-974-0565	P: 737-443-5230	P: 210.366.4358	P: 210.485.3700
F: 817.509.0011	F: 512.261.4803	F: 469.913.6894	F: 713.277.7219	F: 865-338-5604	F: 817.284.2701	F: 469-608-2072	F: 737-402-7698	F: 210.366.4896	F: 210.390.1738

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