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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Radicava® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)
<p>Continuation of therapy: Is this a continuation of prior therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" to the above question, please submit documentation (e.g., medical records, chart notes, pharmacy claims) or provide the dates, duration, and previous regimen used below: (REQUIRED)</p> <hr/> <hr/>

<p>Select the diagnosis below: <input type="checkbox"/> Early amyotrophic lateral sclerosis (ALS) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>

<p>Clinical Information: Is Radicava being used as an adjunct to riluzole? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have minimum disease duration of 3 years? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient live independently? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have a forced vital capacity (FVC) greater than or equal to 70 percent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<p>Reauthorization: For reauthorization requests, also answer the following: Is there documentation (e.g., chart notes, lab values, etc.) indicating improvement? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please submit documentation.</i></p>

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
 For urgent or expedited requests please call 1-855-297-2870.
 This form may be used for non-urgent requests and faxed to 1-844-403-1029.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**
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