

| <b>EDARAVONE (RADICAVA®) PRESCRIBER ORDER FORM</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                |                                                             |         |
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| Patient Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | Date of Birth: |                                                             | Gender: |
| Address:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                |                                                             |         |
| Phone:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | Height:        | <input type="checkbox"/> inches <input type="checkbox"/> cm | Weight: |
| <input type="checkbox"/> lbs <input type="checkbox"/> kg                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                |                                                             |         |
| Clinical Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                |                                                             |         |
| Primary Diagnosis Description: Amyotrophic lateral sclerosis (ALS)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                | ICD-10 Code: G12.21                                         |         |
| Edaravone (Radicava®) Prescription                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                |                                                             |         |
| Edaravone (Radicava®) 30 mg/100 mLs bags refill as directed x 1 year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                |                                                             |         |
| <b>Initial Cycle:</b> <input type="checkbox"/> Infuse 60 mg IV over 60 minutes daily for 14 days followed by a 14-day drug-free period x 1 cycle.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                |                                                             |         |
| <b>Maintenance Cycles:</b> <input type="checkbox"/> Infuse 60 mg IV over 60 minutes daily for 10 days within a 14-day period followed by a 14-day drug-free period. Repeat maintenance cycle every 28 days.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                |                                                             |         |
| Ancillary Orders                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                |                                                             |         |
| <b>Anaphylaxis Kit</b><br>If this is a 1 <sup>st</sup> dose, would you like Option Care Health to provide an anaphylaxis kit with the 1 <sup>st</sup> dose?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                |                                                             |         |
| Dosage: • Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.<br>• Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.<br>• 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                |                                                             |         |
| <b>Medication Orders</b><br><input type="checkbox"/> Lidocaine/prilocaine 2.5%/2.5% (or equivalent) anesthetic cream 30 gm – apply topically 30 min prior to venipuncture or port access as needed for numbing.<br><input type="checkbox"/> Other: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                |                                                             |         |
| <b>IV Flush Orders</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                |                                                             |         |
| <input type="checkbox"/> <u>Peripheral:</u> 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.<br>Heparin (10 unit/mL) 1 to 3 mL post-use.<br>For maintenance, heparin (10 unit/mL) 1 to 3 mL every 24 hr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                |                                                             |         |
| <input type="checkbox"/> <u>Peripheral-Midline:</u> 0.9% Sodium Chloride 3 to 5 mL pre-/post-use, 5 mL pre-lab draw, 10 mL post-draw.<br>Heparin (100 unit/mL) 3 mL post-use.<br>For maintenance, flush with heparin (100 unit/mL) 3 mL every 24 hr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                |                                                             |         |
| <input type="checkbox"/> <u>PICC and Central Tunneled/Non-Tunneled:</u> 0.9% Sodium Chloride 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-draw.<br>Heparin <input type="checkbox"/> (10 unit/mL) 5 mL <u>or</u> <input type="checkbox"/> (100 unit/mL) 3 mL post-use.<br>For maintenance, flush with heparin (10 unit/mL) 5 mL or (100 unit/mL) 3 mL every 24 hr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                |                                                             |         |
| <input type="checkbox"/> <u>Implanted Port:</u> 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw.<br>Heparin (100 unit/mL) 3 to 5 mL post-use.<br>For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                |                                                             |         |
| Skilled nurse to assess and administer and/or teach self-administration, where appropriate, via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.<br>If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                |                                                             |         |
| <i>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                |                                                             |         |
| Prescriber Signature: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                | Date: _____                                                 |         |
| Prescriber Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                |                                                             |         |
| Prescriber Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | Phone:         |                                                             | Fax:    |
| Address:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | NPI:           |                                                             |         |
| City, State:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | Zip:           | Office Contact:                                             |         |
| <b>Fax completed form, insurance information, and clinical documentation to: 713-983-4647</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                |                                                             |         |
| <b>CONFIDENTIAL HEALTH INFORMATION:</b> Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that do not require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted 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 laws. <b>IMPORTANT WARNING:</b> 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 dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners. |  |                |                                                             |         |