

EDARAVONE (RADICAVA®) PRESCRIBER ORDER FORMFax completed form, insurance information, and clinical documentation to: **(888) 822-5060**

Patient Name:		Date of Birth:		
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
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Edaravone (Radicava®) Prescription**Edaravone (Radicava®) 30 mg/100 mLs bags refill as directed x 1 year****Initial Cycle:** Infuse 60 mg IV over 60 minutes daily for 14 days followed by a 14-day drug-free period x 1 cycle.**Maintenance Cycles:** 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****Anaphylaxis Kit**If this is a 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose? Yes – please complete Anaphylaxis Physician Order (FR-PC-036) No**Medication Orders** 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. Other: _____**IV Flush Orders**

- Peripheral: NS 2 to 3 mL pre-/post-use.
Heparin (10 unit/mL) 1 to 3 mL post-use.
For maintenance, heparin (10 unit/mL) 1 to 3 mL every 24 hr.
- Peripheral-Midline: NS 3 to 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw.
Heparin (100 unit/mL) 3 mL post-use.
For maintenance, flush with heparin (100 unit/mL) 3 mL every 24 hr.
- PICC and Central Tunneled/Non-Tunneled: NS 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw.
Heparin (10 unit/mL) 5 mL *or* (100 unit/mL) 3 mL post-use.
For maintenance, flush with heparin (10 unit/mL) 5 mL or (100 unit/mL) 3 mL every 24 hr.
- Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw.
Heparin (100 unit/mL) 3 to 5 mL post-use.
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.

*I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.***Prescriber Signature:** _____ **Date:** _____**Prescriber Information**

Prescriber Name:	Phone:	Fax:
Address:	NPI:	
City, State:	Zip:	Office Contact:

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