EDARAVONE (RADICAVA®) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to: (888) 822-5060

option care health™

Patient Name:			**Date of Birth:**	
Address:				
Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ 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

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:**	

