

Referral Status:	MRN:	
New referral	Order change	Order Renewal
Patient preferred clinic:		

TN F U S I O N PATIENT DEMOGRAPHICS:  Radicava* (Edaravone) Standard Plan of Treatment  PATIENT DEMOGRAPHICS:  Date of Refers.  Patient Name:	IIIII Fairretto						New referral	Order cha	nge	Order Ren	iewal			
Radicava® (Edaravone) Standard Plan of Treatment  PATIENT DEMOGRAPHICS:  Date of Referral: Patient Name:	INFUSION°							Patien	t preferred clinic:					
PATIENT DEMOGRAPHICS:  Patient Name:							reatm	nent						
Patient Name: Date of Birth: Date of						1 1011 01 1	1000							
Date of Birth: Height in inches: Weight: LB or KG Gender: Allergies: See list NKDA  DIAGNOSIS: (PLEASE COMPLETE 2 **D AND 3 **D DIGITS TO COMPLETE ICD 10 FOR BILLING)  G12.21 - Amyotrophic Lateral Sciencesis - Other:  REQUESTED DOCUMENTATION: PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?  I Insurance information   F NO.     F NO.         YES.	Date	of Referral:						Patient's Phone:						
Height in inches: Weight: LB or KG Gender: Allergies: See list NKDA  DIAGNOSIS: (PLEASE COMPLETE 2 <sup>ND</sup> AND 3 <sup>ND</sup> DIGITS TO COMPLETE ICD 10 FOR BILLING)  G12.21 - Amyotrophic Lateral Scienosis	Patie	ent Name:						Address:						
DIAGNOSIS: (PLEASE COMPLETE 2 <sup>NO</sup> AND 3 <sup>NO</sup> DIGITS TO COMPLETE ICD 10 FOR BILLING )  G12.21 - Amystrophic Lateral Sclerosis  Other:  REQUESTED DOCUMENTATION:  In Insurance information  IF NO:  I Insurance information  IF NO:  IF YES:  AST INFUSION DATE:  NEXT INFUSION DATE:  Continue current order until insurance approved biopsy results.  MEDICATION ORDERS:  NOTE: We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans.  PREMEDICATION TO BE ADMINISTERD 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED  PRACE Alabeling advance of the insurance plans.  PREMEDICATION OF DEACH TO BE ADMINISTERD 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED  PRACE Alabeling advance of the insurance plans.  PREMEDICATION OF DEACH TO BE ADMINISTERD 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED  PREMEDICATION OF DEACH TO BE ADMINISTERD 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED  PREMEDICATION OF DEACH TO BE ADMINISTERD 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED  PREMEDICATION OF DEACH TO BE ADMINISTERD 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED  PREMEDICATION OF DEACH TO BE ADMINISTERD 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED  PREMEDICATION OF DEACH TO BE ADMINISTERD 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED  PREMEDICATION OF DEACH TO BE ADMINISTERD 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED  PREMEDICATION OF DEACH TO BE ADMINISTERD 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED  PREMEDICATION OF DEACH TO BE ADMINISTRATION AS SELECTED  PREMEDICATION OF DEACH TO BE	Date	of Birth:						City, State, Zip:						
G12.21 - Amystrophic Lateral Sclerosis  - Other:  REQUESTED DOCUMENTATION:  Insurance information  IF NO:  IF NO:  IF NO:  IF FUS:  IF GOURDED WASHOUT  FROM PREVIOUS  THERAPY:  Indied and falled therapies  THERAPY:  Indied and falled therapies  THERAPY:  IN EVEN:  IF FUS:  IF SUS:	Heigl	nt in inches:	We	eight:		.B or	KG	Gend	er:	Allergies	:	See list	NKDA	
G12.21 - Amystrophic Lateral Sclerosis  - Other:  REQUESTED DOCUMENTATION:  Insurance information  IF NO:  IF NO:  IF NO:  IF FUS:  IF GOURDED WASHOUT  FROM PREVIOUS  THERAPY:  Indied and falled therapies  THERAPY:  Indied and falled therapies  THERAPY:  IN EVEN:  IF FUS:  IF SUS:	DIA	CNOCIC: /DI FACE CO	N 4 F	NI ETE 1	ND AND	2RD DICITE I		ADLET	T ICD 10 FOR BUIL	INC )				
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FOUNT PROVIDED THE PROPERTOR STREET OF THE PROPERTOR OF T			hvsi	cal		_	PLEASE STATE REQUIRED WASHOUT							
Tried and failed therapies   THERAPY:   Lab results and/or tests supporting diagnosis including EMG results, MRI results, Nerve conduction studies, Lumbar puncture or Muscle biopsy results.   Continue current order until insurance approved			11,01	- Cui		REQUIRED W		-						
Lab results and/or tests supporting diagnosis including EMG results, MRI results, Nerve conduction studies, Lumbar puncture or Muscle biopsy results.  MEDICATION ORDERS:  MOIE: We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans.  PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED  FOA lobeling does not suggest premedication prior to infusion  Diphenhydramine   25mg   50mg   40mg   125mg   50mg   40mg   125mg   50mg			es				IOUS							
including EMG results, MRI results, Nerve conduction studies, Lumbar puncture or Muscle biopsy results.    MEDICATION ORDERS:     NOTE: We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans.    NOTE: We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans.    NOTE: We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans.    NOTE: We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans.    NOTE: We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for the treatment through Medicare and/or other insurance plans.    NOTE: We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for the treatment through Medicare and/or other insurance plans.    NOTE: We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for the treatment through Medicare and/or other insurance plans.   Acetaminophen		· ·		porting c	diagnosis	THERAFT.			1					
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Diphenhydramine   25mg   50mg   100mg   Methylprednisolone   40mg   125mg   Other: Famotidine   20mg   40 mg   125mg   Diphenhydramine   25mg   50mg   1000mg   Famotidine   20mg   40 mg   Diphenhydramine   25mg   50mg   Diphenhydramine   25mg   25m														
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Famotidine   20mg   40 mg   Diphenhydramine   25mg   50mg   Cetirizine   10mg   Cetiri		Diphenhydramine		25mg	50mg				Acetaminophen	325mg	500mg	650mg	1000mg	
Famotidine	w	Methylprednisolone		40mg	125m	Other:			Famotidine	20mg	40mg			
MEDICATION/DOSE:  Radicava® (Edaravone) 60 mg/200ml administered IV (2 consecutive 30 mg/100ml IV bags) over a total of 60 minutes  FREQUENCY:  Induction: Once daily for 14 consecutive days, followed by cessation for 14 days  Maintenance: Once daily for any 10 of 14 days, followed by medication free period for 14 days  DURATION:  Continue for months  Other:  LINE USE/CARE ORDERS:  Flush device per facility standard flushing procedure  Cetirizine	'*	Famotidine		20mg	40 mg				Diphenhydramine	25mg	50mg			
Radicava® (Edaravone) 60 mg/200ml administered IV (2 consecutive 30 mg/100ml IV bags) over a total of 60 minutes  FREQUENCY:  Induction: Once daily for 14 consecutive days, followed by cessation for 14 days  Maintenance: Once daily for any 10 of 14 days, followed by medication free period for 14 days  DURATION:  Continue for months  Other:  LINE USE/CARE ORDERS:  Flush device per facility standard flushing procedure  Loratadine 10mg  Other:  SPECIAL/LAB ORDERS:  FREQUENCY:  Continue for 14 days  PRefills x 12 months unless noted otherwise here:  ADVERSE REACTION & ANAPHYLAXIS ORDERS:  Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.								PO	Fexofenadine	60mg	180mg			
consecutive 30 mg/100ml IV bags) over a total of 60 minutes  FREQUENCY:  Induction: Once daily for 14 consecutive days, followed by cessation for 14 days  Maintenance: Once daily for any 10 of 14 days, followed by medication free period for 14 days  DURATION:  Continue for months  Other:  Cher:  Refills x 12 months unless noted otherwise here:  Advienser acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.									Cetirizine	10mg				
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Induction: Once daily for 14 consecutive days, followed by cessation for 14 days  Maintenance: Once daily for any 10 of 14 days, followed by medication free period for 14 days  DURATION:  Continue for months  Other:  EINE USE/CARE ORDERS:  Start PIV/Access CVC  Flush device per facility standard flushing procedure  Refills x 12 months unless noted otherwise here:  ADVERSE REACTION & ANAPHYLAXIS ORDERS:  Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.	FRE	QUENCY:												
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PROVIDER NAME:

ADDRESS:

CITY, STATE, ZIP:

PRESCRIBER SIGNATURE: (No stamp signatures)

Dispense as written/Brand medically necessary

PHONE:

FAX:

NPI:

DATE: