Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

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

Radicava® (Edaravone) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:			Patient's Phone:		
Patient Name:			Address:		
Date of Birth:			City, State, Zip:		
Height in inches:	Weight: LB or KG		Gender:	Allergies: ☐	See list ☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐ G12.21 - Amyotrophic Lateral Sclerosis

☐ _____ - Other:

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	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**

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 ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

FDA labeling does not suggest premedication prior to infusion

IV	Diphenhydramine	☐ 25mg	☐ 50mg			
	Methylprednisolone	☐ 40mg	☐ 125mg	☐ Other:		
	Famotidine	☐ 20mg	☐ 40 mg			
	Other:	☐				

PO	Acetaminophen	☐ 325mg	☐ 500mg	☐ 650mg	☐ 1000mg	
	Famotidine	☐ 20mg	☐ 40mg			
	Diphenhydramine	☐ 25mg	☐ 50mg			
	Fexofenadine	☐ 60mg	☐ 180mg			
	Cetirizine	☐ 10mg				
	Loratadine	☐ 10mg				
	Other:	☐				

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:_____

SPECIAL/LAB ORDERS:

☐ _____

_____

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

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.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	