Radicava Order Form
(edaravone)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

☐ G12.21 Amyotrophic Lateral Sclerosis

Other: _____

Prescribing Information

Patient **MUST** be enrolled with Searchlight Support at 844.772.4548 and have Searchlight Support Patient ID Number. Medication cannot be ordered without this number.

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**
LAB RESULTS: **Include EMG, MRI, nerve conduction studies, lumbar puncture and/or muscle biopsy results as available.**

PRESCRIPTION

RADICAVA (edaravone)

Searchlight Support Patient ID#: _____ **(REQUIRED FOR MEDICATION TO BE ORDERED)**

Loading Dose

☐ **IV:** Infuse two consecutive 30 mg/100 mL IV bags for a total dose of 60 mg/200 mL over 60 minutes, once daily for 14 consecutive days, followed by cessation for 14 days

Maintenance Dose

☐ **IV:** Infuse two consecutive 30 mg/100 mL IV bags for a total dose of 60 mg/200 mL over 60 minutes, once daily for 10 days within a 14 day period (followed by cessation for 14 days) for one year

Post Treatment Observations: The patient is observed for 30 minutes following the first and second administrations.

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

Comments:

_____

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____