RADICAVA™ Infusion

OptiMed
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Please complete each section of the referral form below and fax to OptiMed along with a copy (front and back) of all the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Prescriber Information

Prescriber: _____ **NPI:** _____

Phone: _____ **Fax:** _____ **Office Contact:** _____

Address: _____

Patient Information

Name: _____ **DOB:** _____ ☐**M** ☐**F**

Address: _____

Phone: _____ **2nd Phone:** _____ **SSN:** _____

Primary Language: _____ **Functional Limitations:** _____

Clinical Information

Diagnosis: ☐Amyotrophic lateral sclerosis (progressive muscle atrophy) (G12.21) ☐Other: _____

Weight: _____ ☐lb ☐kg **Height:** _____ ☐in **IV access:** Patient has a ☐PICC ☐Port ☐Other: _____

For patients without established access, OptiMed will utilize a PIV for short-term therapy only. PICC or Port recommended for long-term therapy.

Patient's first dose of RADICAVA™? ☐Yes ☐No; date of last dose _____ ; prior dose (in mg) _____

Allergies: _____ **Latex allergy?** ☐Yes ☐No

History of sulfite allergy? ☐Yes ☐No
asthma? ☐Yes ☐No
kidney disease? ☐Yes ☐No If yes, SCr: _____ GFR/CrCl: _____

Prior treatments & reason for discontinuation: _____

_____

Patient enrolled with SearchLight™ (RADICAVA™ access program)? ☐Yes, ID: _____ ☐No

Additional Notes: _____

_____

_____

_____

Referring provider's preferred site of care*: ☐OptiMed Infusion Center ☐Home Infusion* ☐OptiMed to determine site of care
*Site of care preference is subject to payer limitations, clinical appropriateness, and the availability of servicing providers.

Prescription Information

RADICAVA™ Dosing Regimen	Quantity
☐**Starter Dose:** Once daily 60 mg/200 mL, 60-minute IV infusion for 14 consecutive days, followed by cessation for 14 days.	14 doses (infusions)
☐**Maintenance Dosing:** Once daily 60 mg/200 mL, 60-minute IV infusion for any 10 of 14 days, followed by cessation for 14 days.	_____ doses (infusions)

Site of care: OptiMed Infusion Center (Eligible patients may be transitioned to home infusion following their first dose and as appropriate based on clinical status, patient/provider preference, and payer coverage.)

Prescriber Signature

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide administrative nursing services and supplies in conjunction with the therapy prescribed above.

Signature: _____ **Date:** _____

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CLEAR FORM