Radicava® Referral Form

PHONE: 1-800-277-7302 FAX: 1-866-374-6663 Email: intake@healthcoga.com ☐ ***Initial Order*** ☐ ***Reorder***

Demographics Information: Today's Date ___________________

Patient Name: ____ DOB: ___________________________

Address: ____ City: __________________ State: GA Zip: _________

Phone #: ______________________________ ☐ Cell Alternate Phone #: ___________________________ ☐ Cell

Height: _______ in/ft Weight: ________ lbs/kg Date weight recorded: __________ Last 4 of SSN#__________

Allergies: ____ ☐ **NKDA**

Diagnosis Information:

☐ Amyotrophic lateral sclerosis G12.21 ☐ Other Diagnosis/ICD10Code_________________________

Date Infusion to Begin: _________________________

Previous Infusion Reaction: ☐ YES ☐ NO

List Reactions: _______________________________

Is this a first infusion? ☐ YES ☐ NO

Date of Last Infusion: ______________________________

List of Failed Therapies: ____________________________

Assessment Questions: *Please Provide Appropriate Documentation : EMG and Nerve Conduction Study*

Diabetes? ☐ Yes ☐ No HTN? ☐ Yes ☐ No Cardiac History? ☐ Yes ☐ No Difficulty Breathing? ☐ Yes ☐ No

Requires Oxygen? ☐ Yes ☐ No Confusion /Disorientation? ☐ Yes ☐ No Neuro History? ☐ Yes ☐ No

RADICAVA (edaravone): J1301

☐ **Initial treatment cycle:** 60 mg IV daily for 14 days followed by a 14-day drug-free period.

☐ **Subsequent treatment cycles:** 60mg daily dosing for 10 days out of 14-day periods, followed by 14-day drug-free periods for _________ months.

Pre-Medications: Patient to provide and take 30 minutes prior to infusion

☐ Benadryl 25 MG PO x1 ☐ Benadryl 50 mg PO x1

☐ Acetaminophen 325 mg PO x1 ☐ Acetaminophen 650 mg PO x1

☐ Other Pre-medication: ____________________________________

Access: ☐ **Midline** ☐ **PORT** ☐ **PICC Route:** ☐ **IV**

Catheter Care/Flush: To gain access, use for any ordered pre-medications, and/or PRN to maintain access and patency

Midline – NS 10ml: Qty 2, Heparin 5mL 10units/mL x 1 per infusion

PORT – NS 10ml: Qty 2, Heparin 5mL 100units/mL x 1 per infusion.

PICC – NS 10ml: Qty 2, Heparin 5mL 10units/mL x 1 per infusion

Supplies: (please strike through if not required)

Administration Supplies (A4222) – 1 per infusion

Catheter Care Supplies (A4221) – 1 per week

Infusion Pump (E0781)

Nursing services to administer medications

Administer the anaphylaxis protocol for adverse reactions

Provider signature: ____

NPI # ______________________________ Phone _________________________ Fax ________________________

Office Address: ____________________________________ City: _____________________ St. GA Zip: _________

Printed MD Name: ___________________________________ Contact Name: _______________________________

☐ Demographic information ☐ Patient Ins. Card ☐ H & P ☐ Office notes ☐ Failed therapies in documentation

☐ Up to date medication list