

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB: _____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

☐ NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

☐ G12.21 Amyotrophic Lateral Sclerosis

☐ Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication), signed prescription order and recent visit notes.
Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

☐ Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mgPO

☐ Cetirizine (Zyrtec) 10mgPO

☐ Loratadine (Claritin) 10mgPO

☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV

☐ Other: _____ Dose: _____ Route: _____

Lab Orders

Required: EMG, MRI, nerve conduction studies, lumbar puncture and/or muscle biopsy results if available

☐ Other: _____

RADICAVA (edaravone) (Select one):

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

Initial Cycle:

☐ 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 Cycles:

☐ 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 required to stay for 30 minutes following the first administration.

☐ Refills: ☐ zero ☐ 6 months ☐ 12 months ☐ _____ (Prescription valid for one year, unless otherwise indicated)

Special Instructions: _____

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

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

Provider Name (Print)

Provider Signature

Date