# 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 infusion-related nursing services and supplies in conjunction with the therapy prescribed above.

**Signature:** _____ **Date:** _____

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