Field Name	Field Description
Prior Authorization Group Description	**Radicava**
Drugs	Edaravone (Radicava), Radivaca ORS (edaravone) and any other newly marketed agent *** riluzole (Rilutek) is Preferred and does not require prior authorization***
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, the Drug Package Insert, and/or per the standard of care guidelines
Exclusion Criteria	N/A
Required Medical Information	See "other criteria"
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist
Coverage Duration	If the criteria are met, requests will be approved for up to 6 month duration
Other Criteria	**Initial Authorization:** • Member must have a diagnosis of ALS • Member must have a documented baseline evaluation of functionality using the revised ALS functional rating scale (ALSFRS-R) score ≥ 2 • Member's disease duration is 2 years or less • Member has a baseline forced vital capacity (FVC) of ≥ 80% • Member has been on riluzole (Rilutek), is beginning therapy as an adjunct to treatment with Radicava, or provider has provided a medical reason why patient is unable to use riluzole • Dose is within FDA approved limits **<u>Reauthorization:</u>** • Member is not ventilator-dependent • Provider documents clinical stabilization in symptoms (e.g. stabilization of ALSFRS-R score) • Dose is within FDA approved limits
Revision/Review Date 4/2025	**Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**