RADICAVA™ Infusion Referral Form

University Hospitals
Home Care Services

4510 Richmond Road
Warrensville Heights, OH 44128
Phone: 800-552-8442
Fax: 216-201-5127

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

Prescriber Info.

Prescriber: ______________________ **NPI:** ______________________

Phone: ______________ **Fax:** ______________ **Office Contact:** ______________

Address: ____

____

Patient Information

Name: ______________________ **DOB:** ______________ ☐**M** ☐**F**

Address: ____

Phone: ______________ **2nd Phone:** ______________ **MRN:** ______________

Primary Language: ______________ **Functional Limitations:** ______________________

Clinical Information

Diagnosis: ☐Amytrophic lateral sclerosis (progressive muscle atrophy) (G12.21) ☐Other: ______________

Weight:__________ ☐lb ☐kg **Height:**__________ ☐in **Patient's first dose?** ☐Yes ☐No (If no, date of last dose: __________)

IV access: Patient has a ☐PICC ☐Port ☐Other: ______________

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

Allergies: ____

Latex allergy? ☐Yes ☐No **History of sulfite allergy?** ☐Yes ☐No

History of asthma: ☐Yes ☐ No **History of 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: ____

____

____

____

Prescription Information

Dosing Regimen	Quantity
☐**Radicava™ 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)
☐**Radicava™ 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: Home Care 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 Home Care 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:** ______________

Confidentiality statement: This message is intended only for the individual or institution to which it is addressed. This may contain information, which is confidential, privileged, and/or proprietary. This information may be exempt from disclosure under applicable laws including but not limited to HIPAA. If you are not the intended recipient, please note you are strictly prohibited from distributing, copying, or disseminating this information. If you received this information in error, please notify the sender noted above and destroy all transmitted material.