REALRx

Healthy U
Health Choice Utah

PRIOR AUTHORIZATION REQUEST FORM
RADICAVA®

For authorization, please answer each question and fax this form PLUS chart notes back to the RealRx Medicaid Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for Pharmacy Customer Service for assistance.

- Healthy U Medicaid: 855-856-5694
- Health Choice Utah: 855-864-1404

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Radicava (edaravone) oral suspension

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the prescriber a neurologist, neuromuscular disease specialist, or a physician specialized in amyotrophic lateral sclerosis (ALS)?	☐	☐	
2. Does the member have a Forced Vital Capacity of 80% or greater?	☐	☐	**Please provide documentation**
3. Has the member had a duration of the disease for 2 years or less?	☐	☐	**Please provide documentation**
4. Is the member currently taking riluzole OR have clinical documentation showing a contraindication to riluzole therapy?	☐	☐	**Please provide documentation**
5. Does the member have documentation showing an ALSFRS-R score?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

PRESCRIBER CERTIFICATION	
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.	
Physician's Signature:	**Date:**

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Policy: PHARM-MM-152
Origination Date: 01/05/2023
Reviewed/Revised Date: 01/14/2026
Next Review Date: 01/14/2027
Current Effective Date: 02/01/2026

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