RADICAVA (edaravone) Referral Order Form

FAX (877) 637-6691

VASCO INFUSION
WWW.VASCOINFUSION.COM
PH: 602-346-0204 FAX: 877-637-6691

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions *indicate name of drug(s) _____

Vasco Infusion can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____ Date: _____

DOB: _____ SS# _____

Sodium bisulphate allergy: ☐ Yes ☐ No

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

_____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

NPI / TIN: _____ _____

RADICAVA MEDICATION ORDERS

Refills: _____

INITIAL CYCLE

☐ Infuse 60mg over 60 mintes for 14 consecutive days on, 14 consecutive days off

SUBSEQUENT CYCLES

☐ Infuse 60mg over 60 minutes for 10 out of 14 days on, followed by 14 consecutive days off

INDICATION/DIAGNOSIS

☐ Amyotrophic Lateral Sclerosis (ALS)
☐ Other *(please specify in notes)*

***ICD-10** _____ **required**

_____ _____

Referring Physician's Signature Date

NOTES (ADDITIONAL INFO)

REQUIRED DOCUMENTATION

☐ Recent Office notes - along with any therapies tried and outcomes
- signs of LMN degeneration

☐ Lab Results - including neuro imaging

☐ Insurance Cards (front and back)

☐ Demographic Sheet

☐ Current Medication List

☐ History and Physical Report

☐ ALSFRS - R

☐ Power of attorney (if applicable)

☐ Home Infusion mandate:
- Home bound status letter from doctor
- Specific documentation in clinicals

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY