

Fax completed form to: 1-866-868-0858

Questions, please call: 1-866-316-6049

**TODAY'S OPTIONS<sup>®</sup>**

**Important Information About Prescription Drug Coverage**

To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

Re: Rilutek<sup>®</sup> (Riluzole): Prior Authorization Request Form: Please respond.

- Please complete the attached Rilutek<sup>®</sup> (Riluzole) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

**Please note:** By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

Information about this drug

Rilutek<sup>®</sup> (Riluzole)

The effects of riluzole in amyotrophic lateral sclerosis (ALS) are marginal. A Cochrane review has suggested that riluzole produces a small effect on limb function, but not muscle strength. Overall the median increase in survival is only 2 to 3 months. The American Academy of Neurology has recommended that patients who are most likely to benefit from ALS treatment include the following: definite or probable diagnosis of ALS by El-Escorial criteria, symptoms present for less than 5 years, a vital capacity less than 60% predicted, and no tracheostomy. Please consider the appropriateness of riluzole given these criteria.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

**Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.**

MemberHealth, LLC, PO Box 391197, Solon OH 44139-3911

Last Updated: 12/12/2007

M0018\_TO\_PaTemp\_1107 CMS 11/28/07 H3333/H5421

# Prior Authorization Request Form

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## Patient Information

Name \_\_\_\_\_  
Member ID \_\_\_\_\_  
Medicare ID \_\_\_\_\_  
Date of birth \_\_\_\_\_ Sex: M / F  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_  
Nursing home resident? YES / NO  
Home care patient? YES / NO

## Prescriber and Pharmacy Information

Name \_\_\_\_\_  
Specialty \_\_\_\_\_  
DEA \_\_\_\_\_  
NPI \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Pharmacy name \_\_\_\_\_  
NCPDP \_\_\_\_\_  
NPI \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

## All items below this line are for Physician Use Only

### Information for Requested Drug

Strength: \_\_\_\_\_ Dosage form: \_\_\_\_\_ Qty per 30 days: \_\_\_\_\_ Drug is (circle one): Newly prescribed/Refill  
Directions: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

### Rilutek® (Riluzole) Criteria

- 1 Please indicate the patient's diagnosis. Select or specify the correct ICD-9 code. This question must be completed  
 Definite or probable ALS, in whom other causes of progressive muscle atrophy have been ruled out. (ICD-335.20)  
 Other (diagnosis and ICD-9): \_\_\_\_\_
- 2 Is the prescribing physician a neurologist or has one been consulted?  
 Yes  No
- 3 Does the patient have any of the following conditions?
  - Hypersensitivity to riluzole
  - Tracheostomy for invasive ventilation Yes  No  
 Liver function tests, urinalysis, complete blood counts, and routine blood chemistry are required every two months during therapy.

Medical Justification: (Attach additional page if necessary): \_\_\_\_\_  
\_\_\_\_\_

Prescriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_