

Patient Information

Patient Name:		DOB:	
Patient Home Phone:	Patient Cell Phone:	Patient Email:	
Emergency/Alternate Contact Name:		Emergency/Alternate Contact Phone:	
NKDA	Allergies:	Weight lbs/kg:	Height:
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change
Last infusion date (if applicable):		_____	
Is the patient pregnant, planning a pregnancy or nursing:		Yes	No
Does the patient need interpreter services:		Yes	No

Provider Information

Referral Coordinator Name:		Referral Coordinator Email:	
Ordering Provider:		Provider NPI:	
Referring Practice Name:		Phone:	Fax:
Practice Address:		City:	State: Zip:

ICD-10 CODE

G12.21 Amyotrophic Lateral Sclerosis (ALS)	Other: _____
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Medication Order

Radicava (Edaravone)	Dose: 60mg IV over 60 minutes	Frequency:	Initiation Therapy: Daily for 14 days, followed by 14 day drug-free period THEN Daily for 10 days out of 14 day period, followed by 14 day drug-free period. Continuation Therapy: Daily for 10 days out of 14 day period, followed by 14 day drug-free period.
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Documentation Required (Note: Send all labs, must include specific labs listed here)

Labs	Insurance Card (front and back)	Current Medications	History/Progress Notes
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Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

Provider Name

Provider Signature

Date

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

Check here if this is a stat order

Patient Information

Patient Name:	DOB:	Sex:	M	F	Fasting:	Y	N
Patient Home Phone:	Patient Cell Phone:						
Emergency/Alternate Contact Name:	Emergency/Alternate Contact Phone:						

Lab Test (Please circle or write in ICD-10)

ALT	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	HIV VIRAL LOAD	Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20
AST	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IgE	J45.4, J45.3, L50.9, J45.40, J45.50
HEPATIC FUNCTION PANEL	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IgG	G35, G36.0
BASIC METABOLIC PANEL	I10, E87.1, Z79.899, E87.5, E80.20, G35, M81.0, M81.8, N18.9	IMMUNOGLOBULIN QUANT IgG, IgM, IgA	G35, G36.0
CALCIUM	M81.0, M81.8	IMMUNOGLOBULIN QUANT IgG, IgM, IgA, IgE	G35, G36.0
CBC (INCLUDES DIFF/PLT)	I10, D64.9, Z00.00, R53.83, G35, C50.011, D70.9, D50.0, D63.1	IRON, TIBC, FER PNL	D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
CBC (H/H, RBC, WBC, PLT)s	I10, Z00.00, Z13.0, D64.9, G35, C50.011, D70.9, D50.0, D63.1	LIPID PANEL	Z79.899, E78.5, E55.9, E78.00, Z00.00, E78.01, E78.2
COMP METABOLIC PANEL	I10, Z79.899, E78.5, E11.9, E78.2, E80.20, G35, M81.0, M81.8, N18.9	MAGNESIUM	I10, Z79.899, R25.2, E83.42, Z00.00
CREATININE	M81.0, M81.8, G35	PSA	R97.20, C61, N40.1, Z12.5, N40.0
C-REACTIVE PROTEIN (CRP)	R53.83, R79.82, M35.3, I10, M06.9, K50.90, K51.90, M32.9, L40.50	PROTHROMBIN TIME-INR	Z79.01, I48.91, I48.0, Z51.81
FERRITIN	D64.9, D50.9, D50.0, D50.8, Z00.00, D63.1, N18.9	TRANSFERRIN SATURATION	D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
G6PD	M1A.9XX0, M1A.9XX1	QUANTIFERON TB GOLD	Z79.899, Z00.00, Z01.84, M06.9, M08.9, M45.0, L40.0, L40.50, K51.90, K50.90
GROWTH HORMONE	E22, C7A.1, E34	TSH	E03.9, I10, E03.8, R53.83, E06.3, E05.00
HBSAG CONFIRMATION	Z11.3, Z36.9, Z20.2, Z11.59, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0	URIC ACID	M10.9, E79.0, I10, Z00.00, M1A.9XX0, M1A.9XX1
HEMOGLOBIN & HEMATOCRIT	D50.9, D64.9, D50.0, D63.1, N18.9	VIT B12/FOLIC ACID	M89.49, E53.8, R53.83, F41.8, F41.9, E05.00
HEMOGLOBIN A1C	E11.9, E11.65, R73.01, Z00.00, I10	VIT D 25- HYDROX	E55.9, Z00.00, R53.83, I10, Z79.899, M81.0, M81.8
HEP B SURF AG	Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0	Miscellaneous Labs Not Listed (Write In)	
HIV 4TH GEN	Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20		
HIV 1/2 AB DIFF	Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20		

Frequency

Prior to each dose Yearly Other: Please Specify Below

Lab Test: _____ Frequency: _____

Lab Test: _____ Frequency: _____

Lab Test: _____ Frequency: _____

Lab Test: _____ Frequency: _____

Provider Name

Provider Signature

Date

Provider Phone