RECOVERY ROOM IV THERAPY, LLP.

Phone: 480-865-3322 Fax: 480-866-8189

Radicava Referral Order Form

Patient Information

Patient Name:	Patient DOB:
Patient Phone #:	Sex of Patient:

Provider Information

Ordering Provider Name:	NPI # of Prescribing Provider:
Office Contact Name:	Office Phone #:
Office Contact Fax #:	Office Contact Email:

Radicava Medication Orders

Dosage

- _____ Initial cycle: 60mg IV once daily for 14 days, followed by a 14-day drug-free period
- _____ Subsequent cycles: 60mg IV once daily for 10 days within a 14-day period, followed by a 14-day drug-free period
- _____ Other _____

Patient Weight: _____ Lbs or _____ Kg

Diagnosis with ICD 10 code **(REQUIRED)**

- Diagnosis: ____ ALS (Amyotrophic lateral sclerosis)
- ___ Other _____
- ICD 10 code _____

Pre-Medication	Refills
• Tylenol _____mg • Benadryl _____ mg __IV or ___PO • Solumedrol IV Push _____ mg • Other _____	• Zero _____ • Treatments for 1 year _____ • Other _____

Required Documentation

○ **Insurance Cards (Front and Back)**	○ **Patient Demographics**	○ **Recent Progress Notes**

Special Instructions/Notes

_____ _____

Prescribing Provider Signature **Date of Signature**