

Pharmacy Prior Authorization Form

Last Reviewed: Nov 2011

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Ampyra (dalfampridine)

Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Medication and Requested Dose:

Ampyra 10mg twice daily (higher doses will not be approved)

Priority Health precertification requirements:

Authorization requires:

- Diagnosis of multiple sclerosis
- Patient is receiving immunomodulatory therapy (interferon beta, glatiramer, natalizumab, or mitoxantrone) or immunomodulatory therapy not indicated for patient's MS type
- Currently ambulatory, with minimal walking impairment, or use of cane, crutch or brace.
- Creatinine clearance greater than 50 ml/min
- No history of seizure
- Baseline Timed 25-foot walk (T25FW) completed within 8-45 seconds.
- Therapeutic trial of compounded version of 4- aminopyridine (4-AP)
- Continuation: based on results of T25FW and/or significant clinical improvement.

Please Complete the Following Information:

- Diagnosis of Multiple Sclerosis
Date of diagnosis: _____
- Current immunomodulatory therapy: _____
If none, select one of the following:
- Not indicated for this patient's MS type
 - Failure or intolerance to immunomodulatory therapy
 - Other: _____
- Level of walking impairment: :
- Ambulatory without aid, able to walk without aid or rest some 100 to 500 meters
 - Intermittent or unilateral constant assistance (cane, crutch, brace) required to walk about 100 meters with or without resting
 - Constant bilateral assistance (canes, crutches, braces) required to walk about 20 meters without resting
 - Unable to walk beyond approximately five meters even with aid, essentially restricted to wheelchair; wheels self in standard wheelchair and transfers alone; up and about in wheelchair some 12 hours a day. (Not eligible for Ampyra)
- Creatinine clearance: _____

- History of seizure: Yes No
- Baseline Timed 25-foot walk (T25FW) Results: _____ Date: _____
- Therapeutic trial of compounded 4-AP (Note: 4-AP is a chemical, commercially available to pharmacies for compounding, and is considered medically acceptable for this indication). Yes No

If no, rationale:

If yes, therapeutic outcome:

- Other rationale if the above criteria are not met:

Initial approval will be for 12 weeks. Recertification will be required every 6 months thereafter.

Continuation:

- Results of T25FW after first 12 weeks: _____
- At least 20% improvement in walking speed from baseline: Yes No
- If not 20% improvement in T25FW, please include any clinical notes, information on improvements in functionality, activities of daily living or other relevant clinical measures.

Note: Local Compounding Pharmacies can be found at <http://www.pcab.info/find-a-pharmacy.shtml#mi> that are accredited by the Pharmacy Compounding Accreditation Board (PCAB) to meet the highest standards for pharmaceutical compounding.

*** All fields must be complete and legible for Prior Authorization Review***

**Please fax this request to: (877)974-4411 toll free or (616)942-8206
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**