

Pharmacy Prior Authorization Form

Last Reviewed: Nov 11

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).
- 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.
- 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: _____
- 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: _____
- 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.

FOR MEDICARE ONLY

If none of the above precertification criteria is applicable to this member, please check off which, if any, of the following apply:

1. All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
2. The number of doses available under a dose restriction for the prescription drug:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
3. The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
 - c. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
4. None of the above apply

****If you selected 1, 2, or 3 above, supporting evidence/documentation is required for review. If no supporting evidence/documentation is provided, this request will not be approved.**

***** 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**