Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**

This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Ampyra® (dalfampridine)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product:
☐ Ampyra 10 mg tablet
☐ dalfampridine 10mg tablet

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

Note: Doses exceeding 10 mg twice daily will not be approved.

Precertification Requirements

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived. Initial approval is for 12 weeks.

1. Diagnosis of multiple sclerosis to improve walking
2. Patient is currently ambulatory, with minimal walking impairment or use of cane, crutch or brace
3. Patient does not have a seizure history
4. Patient has a creatinine clearance (CrCl) greater than 50 mL/minute
5. A baseline Timed 25-Foot Walk (T25FW) completed within 8 – 45 seconds

For continuation, patient must have met the following requirements every 12 months:

1. Based on results of T25FW and/or significant clinical improvement

Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 11/2018

Last reviewed 11/2018

PriorityHealth

New request––Priority Health Precertification Documentation

A. What is the patient's diagnosis?

- ☐ Improve walking speed due to multiple sclerosis
- ☐ *Other – the patient's condition is:* _____

B. What is the patient's current level of walking impairment?

- ☐ Ambulatory without aid (able to walk without aid or rest 100 to 500 meters)
- ☐ Intermittent or unilateral constant assistance (cane, crutch, or brace) is required
- ☐ Constant bilateral assistance (canes, crutches, or braces) is required
- ☐ Unable to walk beyond five meters even with aid (essentially restricted to wheelchair)

C. Does the patient have a history of seizures?

☐ No ☐ Yes – rationale for use: _____

D. What is the patient's creatinine clearance? _____ mL/minute

E. What is the result of the patient's baseline timed 25-foot walk (T25FW) test? _____ seconds

Continuation––Priority Health Precertification Documentation

A. What is the result of the patient's most recent time 25-foot walk? _____seconds on _____ (date)
Rationale to demonstrate significant clinical improvement from baseline walk test results:

_____

_____

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Ampyra likely be the most effective option for this patient?
☐ Yes ☐ No
If yes, please explain why: _____

_____

_____

If the patient is currently using Ampyra, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ Yes ☐ No
If yes, please explain: _____

_____

_____

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Last reviewed 11/2018