

# 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.

## Dalfampridine ER

### 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:  dalfampridine 10mg tablet  
 Start date (or date of next dose): \_\_\_\_\_  
 Date of last dose (if applicable): \_\_\_\_\_  
 Dosing frequency: \_\_\_\_\_

### Prior authorization criteria

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.

#### For this drug to be covered, the patient must meet the following criteria:

1. Must be used to improve walking in multiple sclerosis or another medically-accepted indication\*
2. Must not have a history of seizures
3. Must have a creatinine clearance (CrCl) greater than 50 mL/minute
4. Must have a baseline Timed 25-Foot Walk (T25FW) completed within 8 – 45 seconds
5. Must be currently ambulatory with minimal walking impairment or use of cane, crutch or brace

#### For continuation, patient must have met the following requirements:

1. Continuation is 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)

**Additional information**

**Note:** When criteria are met, initial approval is 12 weeks. Subsequent (continuation) approvals are for 12 months.

**New request—Priority Health Precertification Documentation**

**A. What is the patient’s diagnosis?**

- Improving walking speed due to multiple sclerosis
- Other – the patient’s condition is: \_\_\_\_\_  
**Rationale for Other use:** \_\_\_\_\_

**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. **Are you requesting an exception to the criteria?**
  - Yes. **Rationale for exception:** \_\_\_\_\_
  - No

**D. Is the patient’s creatinine clearance greater than 50 mL/minute?**

- Yes. CrCl: \_\_\_\_\_ Date of lab: \_\_\_\_\_
- No. **Are you requesting an exception to the criteria?**
  - Yes. **Rationale for exception:** \_\_\_\_\_
  - No

**D. Is the patient’s baseline timed 25-foot walk (T25FW) test between 8 and 45 seconds?**

- Yes. T25FW: \_\_\_\_\_seconds Date: \_\_\_\_\_
- No. **Are you requesting an exception to the criteria?**
  - Yes. **Rationale for exception:** \_\_\_\_\_
  - No

**Continuation—Priority Health Precertification Documentation**

**A. Has the patient’s T25FW increased?**

- Yes. T25FW: \_\_\_\_\_seconds Date: \_\_\_\_\_
- No. **What is your rationale for continuing with Ampyra?** \_\_\_\_\_

**B. Has there been significant clinical improvement since starting Ampyra?**

- Yes. Please explain: \_\_\_\_\_
- No. **Are you requesting an exception to the criteria?**
  - Yes. **Rationale for exception:** \_\_\_\_\_
  - No

---

**Priority Health Medicare Exception Request** *(exceptions to the above criteria)*

**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 dalfampridine likely be the most effective option for this patient?**

Yes  No

If yes, please explain why: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**If the patient is currently using dalfampridine, would changing the patient's current regimen likely result in adverse effects for the patient?**

Yes  No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_