PriorityHealth

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)

All fields must be complete and legible for review. Your office will receive a response via fax.

Created 02/2019
No changes made since 02/2019
Last reviewed 11/2019

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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

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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: _____

_____

_____

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