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Ampyra (dalfampridine) Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004 or Provider Help Desk at 1-800-454-3730.

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization is required for dalfampridine (Ampyra™). Payment will be considered under the following conditions: 1) Patients must be diagnosed with a gait disorder associated with multiple sclerosis (MS), 2) Initial authorizations will be approved for 12 weeks with a baseline timed 25-foot walk (T25FW) assessment, 3) Additional prior authorizations will be considered at six month intervals after assessing the benefit to the patient as measured by a 20 percent improvement in the T25FW from baseline. Renewal will not be approved if the 20 percent improvement is not maintained. Prior authorizations will not be considered for patients with a seizure diagnosis or in patients with moderate or severe renal impairment.

Preferred	**Nonpreferred**
☐ **Dalfampridine ER**	☐ **Ampyra**

Result of the baseline T25FW assessment: _____
Date of the baseline T25FW assessment : _____
Result of subsequent T25FW assessment: _____

Date of subsequent T25FW assessment_____

Percent improvement from baseline assessment_____

Patient has a seizure diagnosis: ☐ Yes ☐ No

Patient has moderate to severe renal impairment: ☐ Yes ☐ No

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior authorization of benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.