PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Ampyra

Phone: 800-728-7947   Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

	Prescriber Name:
Patient Name:	**Supervising Physician:**
Member/Subscriber Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is the prescriber a Neurologist?   ☐ Yes   ☐ No
Q2. Is the patient ≥18 years of age?   ☐ Yes   ☐ No
Q3. Does the patient have a diagnosis of multiple sclerosis?   ☐ Yes   ☐ No
Q4. Please provide ICD code(s) for diagnosis.
Q5. Will the patient be taking Ampyra in COMBINATION with a disease modifying agent for multiple sclerosis (Aubagio, Avonex, Copaxone, Extavia, Betaseron, Gilenya, Rebif, Tecfidera, or Tysabri)?   ☐ Yes   ☐ No
Q6. Has the patient been OBJECTIVELY assessed for functional impairment related to ambulation AND is this DOCUMENTED in the patient's chart?   ☐ Yes   ☐ No
Q7. Does the patient have a history of seizures?

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☐ Yes   ☐ No
Q8. Does the patient have moderate or severe renal impairment (i.e. CrCl less than or equal to 50 ml/min)? ☐ Yes   ☐ No
Q9. Is the patient a new start to Ampyra? ☐ YES - Patient is a NEW START to Ampyra [SKIP Q10] ☐ NO - Patient has been taking Ampyra for at least 12 WEEKS [PROCEED TO Q10]
Q10. Measured by OBJECTIVE office testing, has the patient had clinically significant, sustained improvement (at least 25% improvement from baseline) in ambulation or functional status, AND there is DOCUMENTATION of this in the patient's chart? ☐ Yes   ☐ No
Q11. Additional Comments

_____   _____
                    Prescriber Signature   Date

☐ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

Scott&White
HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

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