

**PRIOR AUTHORIZATION REQUEST FORM**

**Medicare Part D Ampyra  
(dalfampridine)**

**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.

<b>Patient Name:</b>	<b>Prescriber Name: Supervising Physician:</b>	
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 prescribing physician a neurologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q2. For which diagnosis is Ampyra (dalfampridine) being prescribed? <input type="checkbox"/> Multiple Sclerosis (MS) <input type="checkbox"/> Other (please specify)
Q3. Please provide ICD code(s) for diagnosis.
Q4. If requested indication is MS, does the patient have a diagnosis of remitting-relapsing multiple sclerosis? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q5. If requested indication is MS, does the patient have difficulty ambulating, measured with 25 feet timed gait test? <input type="checkbox"/> Yes <input type="checkbox"/> No

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<b>Patient Name:</b>	<b>Prescriber Name: Supervising Physician:</b>
Q6. Is patient a NEW START to Ampyra treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Will Ampyra be used concomitantly with a disease-modifying agent for multiple sclerosis (teriflunomide, interferon beta-1a, interferon beta-1b, glatiramer, fingolimod, dimethyl fumarate, natalizumab)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. 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

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