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.

Patient Name:	**Prescriber 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 prescribing physician a neurologist?

☐ Yes ☐ No

Q2. For which diagnosis is Ampyra (dalfampridine) being prescribed?

☐ Multiple Sclerosis (MS)
☐ 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?

☐ Yes ☐ No

Q5. If requested indication is MS, does the patient have difficulty ambulating, measured with 25 feet timed gait test?

☐ Yes ☐ No

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Q6. Is patient a NEW START to Ampyra treatment?

☐ Yes ☐ 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)?

☐ Yes ☐ 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