PRIOR AUTHORIZATION REQUEST
Ampyra

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. Has this plan authorized Ampyra in the past for this patient (that is, previous authorization is on file under this plan)?

   ☐ Yes - **please answer question 2 only**

   ☐ No - **please answer questions 3 – 9**

2. ☐ Yes ☐ No Did the patient experience at least 20% improvement in timed walking speeds on a 25-ft walk test since starting Ampyra (within 4 weeks of starting Ampyra)?

3. ☐ Yes ☐ No Does the patient have a documented diagnosis of multiple sclerosis?

4. ☐ Yes ☐ No Is the patient wheelchair-bound?

5. ☐ Yes ☐ No Does the patient multiple sclerosis with one of the following: 1) impaired walking ability defined as a baseline 25-ft walking test between 8 and 45 seconds; OR 2) Expanded Disability Status Scale (EDSS) between 4.5 and 6.5?

6. ☐ Yes ☐ No Does the patient have a history of seizures?

7. ☐ Yes ☐ No Does the patient have moderate to severe renal impairment (creatinine clearance less than 50 mL/minute)?

8. ☐ Yes ☐ No Is the patient stabilized on disease modifying therapy for multiple sclerosis (that is no recent MS exacerbations)?

If you have any questions, call: 800-753-2851

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9. ☐ Yes ☐ No Is Ampyra being prescribed by, or in consultation with a neurologist?

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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