FAX Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
DALFAMPRIDINE (AMPYRA)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

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 6 month intervals after assessing the benefit to the patient as measured by a 20% improvement in the T25FW from baseline. Renewal will not be approved if the 20% 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 **Non-Preferred**

☐ Dalfampridine ER ☐ Ampyra

Strength **Dosage Instructions** **Quantity** **Days Supply**

_____ _____ _____ _____

Diagnosis: _____

Result of the baseline Timed 25-foot Walk (T25FW) assessment: _____

Date of the baseline T25FW assessment : _____

Result of subsequent T25FW assessment: _____

Date of subsequent T25FW assessment:_____

% improvement from baseline assessment:_____

Patient has a seizure diagnosis: ☐ Yes ☐ No

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

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____

***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.