pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

AMPYRA (dalfampridine ER) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for Ampyra are located in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapters – **Multiple Sclerosis Agents** and **Quantity Limits/Daily Dose Limits** accessible at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	total pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested: ☐Ampyra tablet *(preferred)* ☐dalfampridine ER tablet *(non-preferred)*	Strength:	Quantity:	Refills:
Directions:			
Diagnosis *(submit documentation)*:		Dx code (*required*):	
Multiple Sclerosis Agents are part of the DHS Specialty Pharmacy Drug Program (SPDP). Which specialty pharmacy will be used?		☐Diplomat Specialty Pharmacy ☐Walgreen's Specialty Pharmacy	

Initial requests	
1. Does the beneficiary have a diagnosis of multiple sclerosis?	☐Yes – *Submit documentation of diagnosis.* ☐No – *Submit documentation supporting the use of Ampyra for the beneficiary's diagnosis.*
2. Is the requested medication prescribed by a neurologist or physical medicine and rehabilitation specialist (PM&R)?	☐Yes ☐No – specialty: _____
3. Does the beneficiary have motor dysfunction on a continuous basis that impairs the ability to complete instrumental activities of daily living (IADLs) or activities of daily living (ADLs) despite treatment?	☐Yes ☐No *Submit documentation.*
4. Does the beneficiary have a history of seizures?	☐Yes ☐No *Submit documentation.*
5. Does the beneficiary have a creatinine clearance of ≤ 50 ml/min?	☐Yes ☐No *Submit documentation of lab results.*
6. ***For dalfampridine ER (non-preferred) requests:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agent, **Ampyra**?	☐Yes ☐No *Submit documentation.*
Renewal requests	
1. Does the beneficiary have a documented improvement in motor function since starting Ampyra?	☐Yes ☐No *Submit documentation of beneficiary's response to therapy.*
2. Does the beneficiary have a creatinine clearance of ≤ 50 ml/min?	☐Yes ☐No *Submit documentation of lab results.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: