1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

# Ampyra® Prior Authorization Request Form (Page 1 of 2)

| Member Information (required) | | | Provider Information (required) | | |
|---|---|---|---|---|---|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

| Medication Information (required) | | |
|---|---|---|
| Medication Name: | Strength: | Dosage Form: |
| ❑ Check if requesting **brand** | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

## Clinical Information (required)

**Select the diagnosis below:**
❑ Multiple sclerosis
❑ Other diagnosis:_____ICD-10 Code(s): _____

**Clinical Information:**
Is there physician confirmation the patient has difficulty walking (e.g., timed 25-foot walk test)? ❑ **Yes** ❑ **No**
Does the patient have an expanded disability status scale (EDSS) score less than or equal to 7? ❑ **Yes** ❑ **No**
Is the patient restricted to using a wheelchair (if EDSS score is not measured)? ❑ **Yes** ❑ **No**
Is Ampyra prescribed by or in consultation with a neurologist? ❑ **Yes** ❑ **No**

**Reauthorization:**
**If this is a reauthorization request, answer the following questions:**
Is there physician confirmation the patient's walking has improved with Ampyra therapy? ❑ **Yes** ❑ **No**
Does the patient have an expanded disability status scale (EDSS) score less than or equal to 7? ❑ **Yes** ❑ **No**
Is the patient restricted to using a wheelchair (if EDSS score is not measured)? ❑ **Yes** ❑ **No**

**Quantity Limit Requests:**
What is the quantity requested per DAY? _____
**What is the reason for exceeding the plan limitations?**
❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

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**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

_____

_____

Please note: This request may be denied unless all required information is received.

**Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.**

**Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.**

**I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.**

**Provider/Representative (and Title):** _____ **Date:** _____

| **PROACT INTERNAL USE ONLY:** | | | | | |
|---|---|---|---|---|---|
| **Clinical Review Decision** | | | | | |
| | **Approved, through** | | | | |
| | **Denied (documentation attached, if necessary)** | | | | |
| **Tracking:** | | | | | |
| 1st Attempt | | 2nd Attempt | | Letter Mailed: | |