



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:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below:					
<input type="checkbox"/> Multiple sclerosis					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical Information:					
Is there physician confirmation the patient has difficulty walking (e.g., timed 25-foot walk test)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have an expanded disability status scale (EDSS) score less than or equal to 7? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the patient restricted to using a wheelchair (if EDSS score is not measured)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is Ampyra prescribed by or in consultation with a neurologist? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have an expanded disability status scale (EDSS) score less than or equal to 7? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the patient restricted to using a wheelchair (if EDSS score is not measured)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Quantity Limit Requests:					
What is the quantity requested per DAY? _____					
What is the reason for exceeding the plan limitations?					
<input type="checkbox"/> Titration or loading dose purposes					
<input type="checkbox"/> 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)					
<input type="checkbox"/> Requested strength/dose is not commercially available					
<input type="checkbox"/> Other: _____					

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of ProAct. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Ampyra_Jan_2018



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

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:

1 st Attempt		2 nd Attempt		Letter Mailed:	
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