

AMPYRA
PRIOR AUTHORIZATION FORM

Ampyra is a Preferred agent on the Medical Assistance Preferred Drug List (PDL) & requires clinical prior authorization. To review the prior authorization guidelines, refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter-Multiple Sclerosis Agents: <http://www.dhs.state.pa.us/publications/bulletinsearch/index.htm>.

Ampyra is also subject to quantity limits – if the requested quantity exceeds the limit, please submit supporting chart documentation (list of limits accessible at: <http://www.dhs.state.pa.us/provider/doingbusinesswithdpw/pharmacyservices/quantitylimitslist/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION

New Renewal Additional Information (PA#: _____)

pages in this request: _____ Office Contact Name: _____ & Phone: (_____) _____

RECIPIENT INFORMATION

Name: _____ Recipient ID#: _____ Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Specialty: _____

NPI#: _____ OR MA Provider ID#: _____ State License#: _____

Prescriber Address: _____ Suite #: _____

City/State/Zip: _____ Phone: (_____) _____ Fax: (_____) _____

Long-term care facility (if applicable) contact name: _____ Phone: (_____) _____

MEDICAL INFORMATION

Ampyra Dosing: Ampyra ER 10 mg BID Other: _____

Quantity: _____ Refills: _____ Weight: _____ pounds or _____ kilograms

Diagnosis: _____ Diagnosis Code: _____ (required)

Which Specialty Pharmacy will be utilized? Diplomat Specialty Pharmacy Walgreens Specialty Pharmacy

Physician Specialty: Neurologist Physical Medicine & Rehabilitation Other: _____

Does the Recipient have results of a recent serum creatinine (SCr) level? Yes – submit documentation No

For All Initial Requests:

1. Does the Recipient have a diagnosis of Multiple Sclerosis? Yes – submit documentation No

2. Is the Recipient currently receiving medication for the treatment of MS (check all that apply and **submit**

documentation)? Aubagio Avonex Betaseron Copaxone Extavia Gilenya Rebif

Tecfidera Tysabri Other: _____

3. Does the Recipient have significant and continuous motor dysfunction that impairs the ability to complete normal daily activities (ADLs or IADLs)? Yes – submit documentation No

4. Does the Recipient have a history of seizures? Yes – submit documentation No

For All Renewal Requests:

1. Document the date Ampyra was started: _____

2. Has the Recipient experienced an improvement in motor function? Yes – submit documentation No

PLEASE FAX COMPLETED FORM WITH CLINICAL INFORMATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____ Date: _____

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