aetna™

Aetna Better Health®

**Fax completed prior authorization request form to** 844-802-1412 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at https://www.aetnabetterhealth.com/Illinois-medicaid

# Dalfampridine
# Pharmacy Prior Authorization Request Form

**Do not copy for future use. Forms are updated frequently.**

**REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification to support diagnosis**

| **Member Information** | | | |
|---|---|---|---|
| Member Name (first & last): | Date of Birth: | Gender: ☐ Male ☐ Female | Height: |
| Member ID: | City: | State: | Weight: |

| **Prescribing Provider Information** | | | |
|---|---|---|---|
| Provider Name (first & last): | Specialty: | NPI# | DEA# |
| Office Address: | City: | State: | Zip Code: |
| Office Contact: | Office Phone | | Office Fax: |

| **Dispensing Pharmacy Information** | | |
|---|---|---|
| Pharmacy Name: | Pharmacy Phone: | Pharmacy Fax: |

| **Requested Medication Information** | | | | |
|---|---|---|---|---|
| Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No | Diagnosis: | ICD-10 Code: | | |
| Are there any contraindications to formulary medications? If yes, please specify: | ☐ Yes | ☐ No | ☐ New request | ☐ Continuation of therapy request |
| Directions for Use: | Strength: | | Dosage Form: | |
| | Quantity: | Day Supply: | Duration of Therapy/Use: | |
| What medication(s) has the member tried and failed for this diagnosis? Please specify below. | | | | |

| **Turn-Around Time for Review** | |
|---|---|
| ☐ Standard – (24 hours) | ☐ **Urgent** – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____ |

| **Clinical Information** | | | | | |
|---|---|---|---|---|---|
| Does member have an impaired walking ability defined as baseline 25-foot walking test between 8 AND 45 seconds? | ☐ Yes | ☐ No | Does member have an expanded Disability Status Scale between 4.5 AND 6.5? | ☐ Yes | ☐ No |
| Is member wheelchair bound? | ☐ Yes | ☐ No | Does member have history of seizures? | ☐ Yes | ☐ No |
| Has there been disease exacerbation in previous 60 days? | ☐ Yes | ☐ No | Does member have moderate to severe renal impairment (CrCl < 50 mL/min)? | ☐ Yes | ☐ No |
| ☐ **Renewal ONLY** | | | | | |
| Was there improvement in timed walking speed on 25-foot walk? | ☐ Yes | ☐ No | Was there stability or improvement in Expanded Disability Status Scale score? | ☐ Yes | ☐ No |

| | | | | | |
|---|---|---|---|---|---|
| Does member have moderate to severe renal impairment CrCl <50 mL/min)? | ☐ Yes | ☐ No | Was an annual Electroencephalography test completed? | ☐ Yes | ☐ No |

**Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.**

**Signature affirms that information given on this form is true and accurate and reflects office notes.**

**Prescribing Provider's Signature:** _____ **Date:** _____

**Please note: Incomplete forms or forms without the chart notes will be returned**

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 866-329-4701 to check the status of a request.