AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM AMPRYA®

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

PATIENT INFORMATION	
Last Name:	First Name:
Medicaid ID Number:	Date of Birth:
Gender: Male Female	Weight in Kilograms:
PRESCRIBER INFORMATION	
Last Name:	First Name:
NPI Number: Phone Number: DRUG INFORMATION Drug Name/Form:	Fax Number:
Strength:	
Dosing Frequency:	
Length of Therapy:	
Quantity per Day:	

(Form continued on next page.)

AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM - AMPRYA®

Patien	t's Last Name: Patient's First Name:
DIAGN	IOSIS AND MEDICAL INFORMATION
Does t	he patient meet the following criteria?
1.	Does the patient have a diagnosis of Multiple Sclerosis (ICD-9 code = 340)? Yes No If No , provide diagnosis:
2.	Does the patient have a gait disorder or difficulty walking? Yes No
3.	Does the patient have a history of seizures? Yes No
4.	Does the patient have moderate to severe renal impairment (Creatinine Clearance [CrCL] \leq 50 mL/min.)?
5.	What is the patient's baseline Timed 25-foot Walk and date?
	Baseline Timed 25-Foot Walk: Date of Timed 25-Foot Walk:
6.	If continuation of Ampyra® therapy, what is the current Timed 25-Foot Walk?
	Current Timed 25-Foot Walk: Date of Timed 25-Foot Walk:
7.	List pharmaceutical agents attempted and outcome:
8.	Medical Necessity: Provide clinical evidence that the preferred agent will not provide adequate benefit:
	iber Signature (Required) Date nature, the Physician confirms the above information is accurate
and ve	rifiable by patient records. include ALL requested information; Incomplete forms will delay the PA process.

Submission of documentation does NOT guarantee coverage.

Revision Date: 08/2017