Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS – FAMILY HEALTH PLAN

Ampyra (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Ampyra (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Ampyra (dalfampridine)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Has this plan authorized Ampyra in the past for this patient (i.e., previous authorization is on file under this plan)? Y N
   [If no, skip to question 3.]
2. Did the patient experience at least 20% improvement in timed walking speeds on a 25-ft walk test since starting Ampyra? Y N
   [No further questions.]
3. Does the patient have a documented diagnosis of multiple sclerosis? Y N
   [If no, then no further questions.]

4. Is the patient wheelchair-bound? Y N
   [If yes, then no further questions.]

5. Does the patient have impaired walking ability as demonstrated by one of the following: A) baseline 25-ft walking test between 8 and 45 seconds, OR B) Expanded Disability Status Scale (EDSS) between 4.5 and 6.5? Y N

   Please provide result: _____

   [If no, then no further questions.]

6. Does the patient have a history of seizures? Y N
   [If yes, then no further questions.]

7. Does the patient have moderate to severe renal impairment (creatinine clearance less than 50 mL/minute)? Y N
   [If yes, then no further questions.]

8. Is the patient stabilized on disease modifying therapy for multiple sclerosis (i.e., no recent MS exacerbations)? Y N
   [If no, then no further questions.]

9. Is the patient 18 years of age or older? Y N
   [If no, then no further questions.]

10. Is Ampyra being prescribed by, or in consultation with a neurologist? Y N

Comments:

_____

_____

I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature Date