Pharmacy Prior Authorization

AETNA BETTER HEALTH MICHIGAN

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 Michigan at **1-855-799-2551**.
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 *(circle drug)*

Ampyra (dalfampridine)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

## Member information

Member name: _____

Member ID: _____

Member Group No.: _____

Member DOB: _____

Member phone: _____

## Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

**Diagnosis:** _____ **ICD Code:** _____

**Circle the appropriate answer for each question.**

1. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 5.]

2. Did the patient experience an improvement of at least 20% in timed walking speed as documented by the T25FW (timed 25-foot walk) from pre-treatment baseline? Y N

   [If no, then no further questions.]

3. Has functional impairment resolved as a result of increased speed of ambulation resulting in the patient being able to complete instrumental Y N

activities of daily living (such as meal preparation, household chores, etc.)?

[If no, then no further questions.]

4. Has the patient been adherent to therapy at least 85% of the time as verified by the Prescriber and the patient's medication fill history? Y N

   [No further questions.]

5. Does the patient have a documented diagnosis of multiple sclerosis with impaired walking ability? Y N

   [If no, then no further questions.]

6. Has documentation of significant and continuous walking impairment that impairs ability to complete normal activities of daily living (such as meal preparation, household chores, etc.) attributable to ambulation or functional status despite optimal treatment for multiple sclerosis been provided? Y N

   [If no, then no further questions.]

7. Does the patient have a baseline 25-ft walking test between 8 and 45 seconds? Y N

   [If yes, skip to question 9.]

8. Is the request for a patient who is ambulatory* AND has an Expanded Disability Status Scale (EDSS)** score greater than or equal to 4.5 but less than 7? Y N

   *Does not require the use of a wheelchair (bilateral assistance is acceptable, such as a brace, cane, or crutch, as long as the patient can walk 20 meters without resting)

   **The Expanded Disability Status Score (EDSS) quantifies disability in eight functional systems: pyramidal, cerebellar, brainstem, sensory, bowel and bladder, visual, cerebral, and other. EDSS scores 1.0 to 4.5 refer to people with multiple sclerosis who are fully ambulatory. EDSS scores 5.0 to 9.5 are defined by increasing impairment to ambulation.

   [If no, then no further questions.]

9. Is the patient on disease modifying therapy for multiple sclerosis? Y N

   [If no, then no further questions.]

10. Is the patient between 18 and 70 years old? Y N

    [If no, then no further questions.]

11. Is the patient wheelchair-bound? Y N

    [If yes, then no further questions.]

12. Does the patient have a history of seizures? Y N

    [If yes, then no further questions.]

13. Does the patient have moderate to severe renal impairment (creatinine clearance less than 50 mL/minute)? Y N

    [If yes, then no further questions.]

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

    [If no, then no further questions.]

15. Does the patient have a diagnosis of spinal cord injury, myasthenia gravis, or a demyelinating peripheral neuropathy (such as Guillain-Barre syndrome), Alzheimer's disease, and Lambert Eaton myasthenic syndrome)? 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**