HIGHMARK HEALTH OPTIONS

Updated: 03/2024
DMMA Approved: 04/2024

Request for Prior Authorization for Ampyra (dalfampridine)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Ampyra (dalfampridine) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Ampyra (dalfampridine) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of multiple sclerosis (MS) and the following criteria is met:

- Member must be at least 18 years of age
- Must be prescribed by or in consultation with a neurologist
- Must be ambulatory and has walking impairment related to MS as evidenced by **one** of the following:
    - Documented timed 25-foot walk test (T25W) between 8 and 45 seconds
    - Documented Expanded Disability Status Scale (EDSS) between 4.5-6.5
- Must provide documentation of a baseline T25W
- Must be receiving, or is intolerant to, treatment with a disease-modifying agent for MS
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria:**
    - Documentation of recent T25W
    - Documentation of improvement as demonstrated by one of the following:
        - Improvement in T25W after starting treatment
        - Improvement in EDSS after starting treatment
        - Description of what improvements have been experienced as a result of treatment
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

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AMPYRA (DALFAMPRIDINE)
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon-Fri 8:00am to 7:00pm

PROVIDER INFORMATION		
Requesting Provider:	NPI:	
Provider Specialty:	Office Contact:	
Office Address:	Office Phone:	
	Office Fax:	

MEMBER INFORMATION		
Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION		
Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No		

Billing Information
This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____
Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information	
Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)
Does the member have a diagnosis of Multiple Sclerosis (MS)? ☐ Yes ☐ No
Is the member ambulatory with walking impairment related to MS? ☐ Yes ☐ No
Did the member complete a baseline Timed 25-foot Walk test? ☐ Yes. time:_____ ☐ No
What is the member's Expanded Disability Status Scale (EDSS)? _____
Is the member currently on treatment for MS? ☐ Yes ☐ No, please explain: _____

REAUTHORIZATION
Did the member complete a timed 25-foot walk test in the past year? ☐ Yes, time:_____ ☐ No
Please indicate which of the following has occurred since initiation of treatment;
☐ Improvement in Timed 25-foot Walk test
☐ Improvement in EDSS, please provide recent EDSS score: _____
☐ Other improvement, please provide detailed description: _____
_____

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date