Updated: 04/2019
DMMA Approved: 04/2019

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

All requests for Firdapse (amifampridine) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Firdapse (amifampridine) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of Lambert-Eaton myasthenic syndrome (LEMS) and the following criteria is met:

- Member is 18 years of age or older
- The prescribing physician is a neurologist
- Must provide documentation of muscle weakness with typical distribution, areflexia, autonomic dysfunction, and **ONE** of the following:
    - Presence of VGCC autoantibodies
    - Electromyograph (EMG) or Nerve Conduction Study (NCS) with adequate repetitive stimulation undertaken in relevant muscles
- Provider attestation that other differential diagnoses such as Myasthenia Gravis have been ruled out
- Provider attestation that the member does not have a history of seizures
- 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:** 3 months
- **Reauthorization criteria**
    - Must provide chart documentation demonstrating improvement of muscle weakness and tolerance
- **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.

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FIRDAPSE (AMIFAMPRIDINE)
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) 325-6253 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

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

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Frequency:	Duration:	
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 (if medically please provide a 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)

Diagnosis: _____
Is documentation of muscle weakness, areflexia, and autonomic dysfunction provided? ☐ Yes ☐ No
Is documentation of VGCC autoantibodies, an electromyograph, or nerve conduction study provided? ☐ Yes ☐ No
Has Myasthenia Gravis or other differential diagnoses been ruled out? ☐ Yes ☐ No
Does the member have a history of seizures? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No
Please describe:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date

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