

Gateway Health
Prior Authorization Criteria
Firdapse (amifampridine)

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 or stabilization of muscle weakness from baseline 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.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.



**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 Gateway HealthSM Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 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:
Gateway ID:	Member weight: _____ pounds or _____ kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date Medication Initiated:	

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

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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