FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Ampyra® & dalfampridine ER Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Multiple sclerosis

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is there physician confirmation the patient has difficulty walking (e.g., timed 25-foot walk test)? ❑ **Yes** ❑ **No**

Does the patient have an expanded disability status scale (EDSS) score less than or equal to 7? ❑ **Yes** ❑ **No**

Is the patient restricted to using a wheelchair (if EDSS score is not measured)? ❑ **Yes** ❑ **No**

Is Ampyra prescribed by or in consultation with a neurologist? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following questions:

Is there physician confirmation the patient's walking has improved with Ampyra therapy? ❑ **Yes** ❑ **No**

Does the patient have an expanded disability status scale (EDSS) score less than or equal to 7? ❑ **Yes** ❑ **No**

Is the patient restricted to using a wheelchair (if EDSS score is not measured)? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ Other:

_____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of FutureScripts. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**