



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:
<input type="checkbox"/> Check if <b>generic substitution</b> is acceptable		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

Clinical Information (required)	
<b>Select the diagnosis below:</b>	
<input type="checkbox"/> Multiple sclerosis (MS)	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
<b>Reauthorization:</b>	
Is there documentation of a 20% improvement in walking speed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Quantity Limit Requests:</b>	
What is the quantity requested per MONTH? _____	
Is there documentation of the inability to reach the requested dose with commercially available dosage forms? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is there documentation the dose requested is medically necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If YES, please specify: _____	

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.

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