OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay the authorization process.***

Drug Requested: **Ampyra®** (dalfampridine) ***(Non-Preferred)*** ***(MEDICAID)***

DRUG INFORMATION: ***Complete all information below or authorization process will NOT be delayed.***

Dosage Form/Strength: _____

Dosing Frequency: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable:*** _____

DIAGNOSIS AND CLINICAL CRITERIA: ***ALL applicable boxes MUST be checked to ensure the authorization process will NOT be delayed.***

- Does the patient have a diagnosis of Multiple Sclerosis (MS) (ICD-9 code = 340)? ❑ Yes ❑ No
  - If *No*, please provide diagnosis. Diagnosis: _____
- Does the patient have a gait disorder or difficulty walking? ❑ Yes ❑ No
- Does the patient have a history of seizures? ❑ Yes ❑ No
- Does the patient have moderate to severe renal impairment (Creatine Clearance [CrCL] ≤ 50mL/min)? ❑ Yes ❑ No
- What is the patient's baseline Timed 25-foot Walk and date? _____
- If continuation of Ampyra® therapy, what is the current Timed 25-Foot Walk?

  Current Timed 25-Foot Walk: _____ Date of Timed 25-Foot Walk: _____

List pharmaceutical drugs attempted and outcome:

1. _____
2. _____

Medical necessity: ***Provide clinical evidence that the preferred drug(s) will not provide adequate benefit.***

_____

_____

Medication being provided by a Specialty Pharmacy - PropriumRx

****Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: 7/1/2018