OPTIMA HEALTH PLAN

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 authorization process.***

Drug Requested: **Ampyra®** (dalfampridine)

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength/Quantity: _____

Dosing Schedule: _____ **Length of Therapy**: _____

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

Maximum recommended dose: 10 mg twice daily with or without food. Patients should not take double or take extra doses if a dose is missed. (Quantity limit of 60 tablets / 30 days)

CLINICAL CRITERIA: Check applicable boxes below. Boxes must be checked to qualify. Information not completed will delay authorization process.

Initial Therapy *(Coverage may be given for 8 weeks in duration)*	**Continuation of Therapy** *(Coverage may be given for 1 year in duration)*
Prescriber is a Neurologist? ❑ Yes ❑ No	Current Timed 25-Foot Walk: _____
Does patient have a diagnosis of MS? ❑ Yes ❑ No	Date of Timed 25-Foot Walk: _____
Does the patient have a history of seizure? ❑Yes ❑ No	Current EDSS score: _____
Does the patient have moderate to severe renal impairment (Creatinine Clearance [CrCl] ≤ 50 ml/min)? ❑ Yes ❑ No	Has patient demonstrated an improvement in walking within the past 2 months? ❑ Yes ❑ No
What is the patient's baseline Timed 25-foot Walk and date? _____	

Physician signature or name of person providing the answers: _____

(signature on next page)

***Medication being provided by** (check applicable box(es) below):*

- ❑ **Physician's office**

  OR

- ❑ **Specialty Pharmacy**: ❑ **Briova SpecialtyRx**

*****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***

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name**:** _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 7/15/2010
REVISED/UPDATED: ~~6/6/2011; 8/11/2011; 4/8/2014; 8/8/2014; 11/6/2014; 5/21/2015~~; ~~12/24/2015~~; ~~9/9/2016; 9/20/2016~~; ~~11/16/2016~~; 12/12/2016; ~~9/12/2017~~; **10/6/2017**;