**Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.**
**Ampyra (dalfampridine) Prior Authorization (PA)**
**Pharmacy Benefits Prior Authorization Help Desk**
**Length of Authorization: 12 months**

**Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage of **Ampyra (dalfampridine).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete.**

**The KP-MAS Formulary can be found at:** Pharmacy | Community Provider Portal | Kaiser Permanente

**1 – Patient Information**

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

**2 – Provider Information**

Provider Name: _____ Specialty: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

**3 – Pharmacy Information**

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

**4 – Drug Therapy Requested**

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

**5– Diagnosis/Clinical Criteria**

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

**Clinical Criteria:**

1. Does the member have a documented diagnosis of multiple sclerosis (MS)? **AND**
   □ No □ Yes □ Other_____

2. Does the patient have a gait disorder or difficulty walking? **AND**
   □ No □ Yes

3. Does the member have a documented baseline timed 25-foot walk test? **AND**
   □ No □ Yes
   Baseline Timed 25-foot walk:_____ Date: _____

4. Member's renal function estimated (using glomerular filtration rate (eGFR) or creatinine clearance (CrCl) to be >50 mL/min, **AND**
   □ No □ Yes

5. Member does not have a history of seizures?
   □ No □ Yes

6. Has the patient tried other agents?
   □ No □ Yes
   Please list the agent and outcome:_____

7. Medical Necessity: Provide clinical evidence that the preferred agent will not provide adequate benefit:
   _____

**For continuation of therapy, please respond to <u>additional questions</u> below:**

1. Does the member have a current documented timed 25-foot walk test?
   □ No □ Yes
   Current Timed 25-foot walk: _____ Date: _____

**6 – Provider Sign-Off**

**Additional Information –**

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

**I certify that the information provided is accurate. Supporting documentation is available for State audits.**

| **Provider Signature:** | **Date:** |
|---|---|
| | |

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