Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Ampyra (Dalfampridine) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 3 months; Continuation- 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.**
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

Prescriber specialty: □ Neurologist □ Other: ____

If consulted with a specialist, specialist name and specialty: ____

Provider Name: _______________________________ 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. Member has a documented diagnosis of multiple sclerosis (MS),
   □ No □ Yes

2. **AND** medication is being prescribed for walking problems specifically related to MS,
   □ No □ Yes

3. **AND** member can walk (not restricted to wheelchair or bed),
   □ No □ Yes

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

5. **AND** member does not have history of seizures,
   □ No □ Yes

6. **AND** member has failed an adequate trial (≥ 3 months) of, or has a documented allergy or intolerance to, or is not a candidate for dalfampridine (generic Ampyra)
   □ No □ Yes

For continuation of therapy, please respond to additional questions below:

1. Member has demonstrated improvement in walking speed or demonstrates improvement in core activities of daily living (e.g., meal preparation or household chores),
   □ No □ Yes

2. **AND** member's dose does not exceed 20 mg per day
   □ No □ Yes

*** Daily doses exceeding 20 mg will not be approved***

7 – 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:**

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

Provider Signature:	**Date:**
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