Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Firdapse (amifampridine phosphate) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Firdapse (amifampridine phosphate).** 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

Is the prescriber a neurologist or in consultation with a neurologist? □ No □ Yes

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

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. Documented confirmed diagnosis of Lambert-Eaton metabolic syndrome (LEMS) based on clinical, serologic, and electrodiagnostic exam
   □ No □ Yes

2. **AND** patient is ≥18 years**,**
   □ No □ Yes

3. **AND** patient is ambulatory,
   □ No □ Yes

4. **AND** patient does NOT have a history of seizures or active brain metastases,
   □ No □ Yes

5. **AND** forced vital capacity (%FVC) ≥60%
   □ No □ Yes

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

1. ECG, renal function and liver function testing completed annually
   □ No □ Yes

2. **AND** member is still ambulatory
   □ No □ Yes

3. **AND** member has NOT developed epileptic seizures
   □ No □ Yes

4. **AND** member is adherent to therapy
   □ No □ Yes

5. **AND** member has documented improvement from baseline
   □ No □ Yes

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:**

_____

_____

_____

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

Provider Signature:	**Date:**