STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

DALFAMPRIDINE

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
DALFAMPRIDINE	AMPYRA, DALFAMPRIDINE ER	13907		GPI-10 (6240603000)	FDB: ROUTE ≠ MISCELL.

GUIDELINES FOR USE

INITIAL CRITERIA (NOTE: FOR RENEWAL CRITERIA SEE BELOW)

1. Does the patient have a diagnosis of multiple sclerosis (MS) and meet **ALL** of the following criteria?
   - The patient is 18 years of age or older
   - Therapy is prescribed by or in consultation with a neurologist
   - The patient has symptoms of a walking disability such as mild to moderate bilateral lower extremity weakness or unilateral weakness plus lower extremity or truncal ataxia

   If yes, **approve for 3 months by HICL or GPI-10 for #2 tablets per day.**
   If no, do not approve.
   INITIAL DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

   Our guideline named **DALFAMPRIDINE (Ampyra)** requires the following rule(s) be met for approval:
   A. You have multiple sclerosis (MS: a type of nerve disorder)
   B. You are 18 years of age or older
   C. Therapy is prescribed by or in consultation with a neurologist (a type of brain doctor)
   D. You have symptoms of a walking disability such as mild to moderate bilateral (both sides) lower extremity weakness or unilateral (one side) weakness plus lower extremity or truncal ataxia (impaired balance or coordination)

   Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

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DALFAMPRIDINE

GUIDELINES FOR USE (CONTINUED)

RENEWAL CRITERIA

1. Does the patient have a diagnosis of multiple sclerosis (MS) **AND** meet the following criterion?
   - The patient has experienced or maintained at least a 15% improvement in walking ability

   If yes, **approve for 12 months by HICL or GPI-10 for #2 tablets per day.**
   If no, do not approve.
   RENEWAL DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

   Our guideline named **DALFAMPRIDINE (Ampyra)** requires the following rule(s) be met for renewal:
   A. You have multiple sclerosis (MS: a type of nerve disorder)
   B. You have experienced or maintained at least a 15% improvement in walking ability

   Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Monograph for Ampyra.

REFERENCES

- Ampyra [Prescribing Information]. Ardsley, NY: Acorda Therapeutics; November 2021.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 08/29/22
Created: 02/10
Client Approval: 07/22
P&T Approval: 07/22