P.O. Box 30192
Salt Lake City, UT 84120-0192
801-442-4912 or 800-442-3219
Fax 801-442-3006

selecthealth℠

PREAUTHORIZATION FORM

Ampyra™
(dalfampridine)

Therapeutic use: Improve walking speed in patients with multiple sclerosis (MS)

Quantity Limit: 10 mg twice daily (bid)

Authorization Period: 2 months initially, documented improvement in walking speed required for 12 month reauthorization

Patient's name _____

Patient's ID# ☐☐☐ ☐☐ ☐☐☐☐ DOB ☐☐/☐☐/☐☐☐☐

ICD-9 ☐☐☐ ☐☐ ☐☐☐ ☐☐ _____

Physician's name_____

Physician's Ph# (☐☐☐) ☐☐☐-☐☐☐☐ Fax# ☐☐☐-☐☐☐☐

Physician's signature_____ Date signed ☐☐/☐☐/☐☐☐☐

Please check "Yes" or "No" or answer the following questions:			
1.	Has the patient been diagnosed with MS?	❑ Yes	❑ No
2.	Is the prescribing physician a neurologist?	❑ Yes	❑ No
3.	Has the patient been **compliant** on at least one other MS drug? If so, please list the other therapies that have been tried in the table below.	❑ Yes	❑ No
4.	What is the patients EDSS score? _____		
5.	What is the patients baseline 25 foot walk time (T25FW)? _____ (sec) For reauthorization, what is the patient's most recent 25 foot walk time? _____ (sec)		
6.	Is the patient confined to a wheelchair?	❑ Yes	❑ No
7.	Does the patient have a history of seizures?	❑ Yes	❑ No
8.	Does the patient have moderate to severe renal impairment (CrCl ≤ 50 mL/min)?	❑ Yes	❑ No

Name of MS Drug	Duration of Therapy	Reason for Discontinuation
a.		
b.		
c.		

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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