Montana Healthcare Programs Prior Authorization Request Form for Use of Ampyra (dalfampridine)

<table>
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<tr>
<th>Member Name:</th>
<th>DOB:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Member ID:</td>
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<tr>
<td>Prescriber Name/Specialty:</td>
<td>Prescriber Phone:</td>
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<td>Prescriber Fax:</td>
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<td>Requested Dose/Directions:</td>
<td>Diagnosis:</td>
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Please complete below information for applicable situation, **Initiation** or **Continuation** of therapy:

**INITIATION OF THERAPY**

1. Member has a gait disorder associated with Multiple Sclerosis? □ Yes □ No
2. Does the member have a diagnosis of a spinal cord injury, Myasthenia gravis, demyelinating peripheral neuropathies (such as Guillain-Barré syndrome), Alzheimer’s disease or Lambert Eaton myasthenic syndrome, or a history of seizures? □ Yes □ No
3. Member is receiving concurrent therapy with a disease modifying agent (i.e., Avonex, Betaseron, Copaxone, Extavia, Rebif, Tysabri)? □ Yes □ No
4. Member is a neurologist or has consulted with a neurologist? □ Yes □ No
5. Member has documentation of significant limitations of instrumental activities of daily living (e.g., meal preparation, household chores) attributable to slow ambulation? [Intermittent occupational tasks that are not required as a daily part of job functioning are not considered instrumental activities of daily living.] □ Yes □ No
6. Member is able to ambulate at least 25 feet? □ Yes □ No
   - Provide baseline T25FW Result: _____________ Date performed: ____________

**LIMITATIONS:** Maximum 2 tablets daily. Initial authorization will be granted for 12 weeks.

**CONTINUATION OF THERAPY:**

1. Member will continue to receive disease-modifying therapy? □ Yes □ No
2. Member has demonstrated an improvement or stabilization of timed baseline walking speed and/or continued improvement in quality of life? □ Yes □ No
   - Provide current T25FW Result: _____________ Date performed: ____________
   - Describe any other measurements you wish to include which demonstrate continued improvement or stabilization:

Reauthorization will be issued for 1 year.

Please complete form and fax to:
Drug Prior Authorization Unit at 1-800-294-1350

1/2020