UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

AMPYRA (dalfampridine)

Patient name:_________________________________Medicaid ID #:______________________________

Prescriber Name:________________Prescriber NPI#:____________ Contact person:____________________

Prescriber Phone#:__________________Extension/Option:_______________ Fax#:___________________

Pharmacy:_____________________Pharmacy Phone#:_______________Pharmacy Fax #:______________

Requested Medication:_____________________________Strength:_________Frequency/Day:__________

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES AND THIS COMPLETED FORM TO 855-828-4992 **note the new fax number**

CRITERIA:

- Minimum age requirement: 18 years old.
- Documented diagnosis of Multiple Sclerosis.
- No history of seizures.
- No history of moderate to severe renal impairment, as evidenced by a creatinine clearance rate greater than or equal to 51mL/min.

AUTHORIZATION:

Initial authorization will be granted for three months. Three months is sufficient to assess efficacy in each patient.

RE-AUTHORIZATION:

Reauthorization period is 1 year
Updated letter of medical necessity including:

- no seizures
- current renal function greater than or equal to 51ml/min
- documented treatment efficacy (i.e. increased walking speed