Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
Dalfampridine (Ampyra™)

This form is used for both preferred and non-preferred agents.
(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

Prior authorization is required for dalfampridine (Ampyra™). Payment will be considered under the following conditions: 1) Patients must be diagnosed with a gait disorder associated with multiple sclerosis (MS). 2) Initial authorizations will be approved for 12 weeks with a baseline Timed 25-foot Walk (T25FW) assessment. 3) Additional prior authorizations will be considered at 6 month intervals after assessing the benefit to the patient as measured by a 20% improvement in the T25FW from baseline. Renewal will not be approved if the 20% improvement is not maintained. Prior authorizations will not be considered for patients with a seizure diagnosis or in patients with moderate or severe renal impairment.

Non-Preferred

Ampyra™ ☐

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis: _____

Result of the baseline Timed 25-foot Walk (T25FW) assessment: _____

Date of the baseline T25FW assessment : _____

Result of subsequent T25FW assessment: _____

Date of subsequent T25FW assessment:_____

% improvement from baseline assessment:_____

Patient has a seizure diagnosis: ☐ Yes ☐ No

Patient has moderate or severe renal impairment: ☐ Yes ☐ No

Attach lab results and other documentation as necessary.
Prescriber Signature: _____ Date of Submission: _____
***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.