Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Ampyra (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Ampyra (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Ampyra (dalfampridine)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Member information

Member name: _____

Member ID: _____

Member Group No.: _____

Member DOB: _____

Member phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

1. Has this plan authorized Ampyra in the past for this member (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 4.]

2. Did the member experience improvement in timed walking speeds on a 25-foot (ft) walk test since starting Ampyra? Y N

   [If yes, then no further questions.]

3. Does the member have a stable or improved Expanded Disability Status Scale (EDSS) score? Y N

[No further questions.]

4. Does the member have a documented diagnosis of multiple sclerosis? Y N

   [If no, then no further questions.]

5. Is the member wheelchair-bound? Y N

   [If yes, then no further questions.]

6. Does the member have impaired walking ability as demonstrated by one of the following: A) baseline 25-foot (ft) walking test between 8 and 45 seconds, OR B) Expanded Disability Status Scale (EDSS) between 4.5 and 6.5? Y N

   Please provide result: _____

   [If no, then no further questions.]

7. Does the member have a history of seizures? Y N

   [If yes, then no further questions.]

8. Does the member have moderate to severe renal impairment (creatinine clearance less than 50 mL/minute)? Y N

   [If yes, then no further questions.]

9. Is the member 18 years of age or older? Y N

   [If no, then no further questions.]

10. Is Ampyra being prescribed by, or in consultation with a neurologist? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**