

SENTARA COMMUNITY PLAN (MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If the information provided is not complete, correct, or legible, the authorization process can be delayed.

Drug Requested: (Check below the drug that applies)

Preferred Medication	Non-Preferred Medication
<input type="checkbox"/> dalfampridine ER (generic Ampyra®)	<input type="checkbox"/> Ampyra®

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

DIAGNOSIS AND CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

1. Does patient have a diagnosis of Multiple Sclerosis (MS) (ICD-10 code = G35)? ☐ Yes ☐ No

If **No**, please provide diagnosis. Diagnosis: _____

2. Does the patient have a gait disorder or difficulty walking? ☐ Yes ☐ No

3. Does the patient have a history of seizures? ☐ Yes ☐ No

4. Does the patient have moderate to severe renal impairment (Creatine Clearance [CrCL] \leq 50mL/min)?

☐ Yes ☐ No

(Continued on next page)

5. What is the patient's baseline Timed 25-foot Walk and date?
Baseline Timed 25-Foot Walk: _____ Date of Timed 25-Foot Walk: _____
6. If continuation of Ampyra® therapy, what is the current Timed 25-Foot Walk?
Current Timed 25-Foot Walk: _____ Date of Timed 25-Foot Walk: _____
7. If requesting brand Ampyra®, member has trial and failure of the **PREFERRED** generic dalfampridine extended release (ER) ☐ Yes ☐ No ☐ N/A

List pharmaceutical drugs attempted and outcome:

Medical necessity: Provide clinical evidence that the **PREFERRED** drug(s) will **not** provide adequate benefit.

Medication being provided by a Specialty Pharmacy - PropriumRx

****Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****