Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Prior Authorization Criteria Form

ARKANSAS BLUE CROSS BLUE SHIELD
Medi-Pak Rx (PDP), Medi-Pak Advantage (PFFS), and Medi-Pak Advantage · St. Vincent (PPO)

Ampyra (Medicare Prior Authorization)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at **1-866-239-8303**.
Please contact CVS|Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Ampyra (Medicare Prior Authorization).

Drug Name (select from list of drugs shown)
Ampyra (dalfampridine)

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Please circle the appropriate answer for each applicable question.

1.	Does the patient have a diagnosis of multiple sclerosis?	Y N
	[If no, then no further questions.]	
2.	Is the patient's creatinine clearance less than or equal to 50 mL/minute?	Y N
	[If yes, then no further questions.]	
3.	Does the patient have a history of seizures?	Y N
	[If yes, then no further questions.]	
4.	Is the prescribed dose greater than 10 mg twice daily?	Y N
	[If yes, then no further questions.]	
5.	Is the patient currently on treatment with Ampyra?	Y N
	[If yes, then skip to question 8.]	
6.	Prior to initiating treatment with Ampyra, did the patient have sustained walking impairment?	Y N

	[If no, then no further questions.]	
7.	Is the patient able to walk 25 feet (with or without assistance)?	Y N
	[No further questions.]	
8.	Has the patient experienced an improvement in walking speed or other objective measure of walking ability since starting Ampyra?	Y N

Comments: _____

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

Prescriber (Or Authorized) Signature and Date