

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

**FAX DOCUMENTATION FROM PROGRESS NOTES AND THIS COMPLETED
FORM TO 855-828-4992**

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 (lab work must be done within the last 6 months)

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)

05/29/2012

<https://medicaid.utah.gov/pharmacy/>