04/18/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Ampyra (IL88)

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 Illinois Medicaid at **1-855-684-5250**.
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Ampyra (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Ampyra (dalfampridine)

Quantity ___________ Frequency _________________ Strength ____________

Route of Administration ___________ Expected Length of therapy _______________

Patient Information

Patient Name: ______________________________________

Patient ID: ______________________________________

Patient Group No.: ______________________________________

Patient DOB: ______________________________________

Patient Phone: ______________________________________

Prescribing Physician

Physician Name: ____________________________

Physician Phone: ____________________________

Physician Fax: ____________________________

Physician Address: ____________________________

City, State, Zip: ____________________________

Diagnosis:________________________________ **ICD Code:**________________________________

Please circle the appropriate answer for each question.

1. Does the patient have a documented diagnosis of multiple sclerosis with impaired walking ability? Y N

   [If no, no further questions.]

2. Is the patient wheelchair-bound? Y N

   [If yes, no further questions.]

3. Did the patient have a baseline 25-ft walking test between 8 and 45 seconds? Y N

   [If no, no further questions.]

4. Does the patient have a history of seizures? Y N

   [If yes, no further questions.]

5. Does the patient have moderate to severe renal impairment (creatinine clearance greater than 50 mL/minute)? Y N

   [If yes, no further questions.]

6. Is the patient on disease modifying therapy for multiple sclerosis? Y N

   [If no, no further questions.]

7. Is the patient 18 years of age or older? Y N

   [If no, no further questions.]

8. Has Aetna Better Health authorized this medication in the past for this patient (i.e., previous authorization is on file under Aetna Better Health)? Y N

   [If no, no further questions.]

9. Has the patient experienced at least 20% improvement in walking speed? Y N

Comments:

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

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Prescriber (Or Authorized) Signature **Date**