



<b>Prior Authorization</b>
<b>JOHNS HOPKINS HEALTHCARE (MEDICAID)</b> Ampyra - Priority Partners MCO
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Johns Hopkins Healthcare at <b>1-410-424-4607</b> . Please contact Johns Hopkins Healthcare at <b>1-888-819-1043</b> with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Ampyra - Priority Partners MCO.

Drug Name (select from list of drugs shown) Ampyra (dalfampridine)
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Quantity	Frequency	Strength
Route of Administration	Expected Length of Therapy	

<b>Patient Information</b>	
Patient Name:	_____
Patient ID:	_____
Patient Group No.:	_____
Patient DOB:	_____
Patient Phone:	_____

<b>Prescribing Physician</b>	
Physician Name:	_____
Physician Phone:	_____
Physician Fax:	_____
Physician Address:	_____
City, State, Zip:	_____

<b>Diagnosis:</b> _____	<b>ICD Code:</b> _____
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Comments: _____
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<b>Please circle the appropriate answer for each question.</b>	
1. Has the plan authorized this medication in the past for this patient (i.e. previous authorization is on file under this plan)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.	
[If yes, skip to question 7.]	
2. Does the patient have a diagnosis of multiple sclerosis?	<input type="checkbox"/> Y <input type="checkbox"/> N

NOTE: Submission of medical records is required.	
[If no, no further questions.]	
3. Does the patient have a documented timed 25-foot walk test?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
4. Does the patient have a creatinine clearance of greater than 50ml per min?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	
5. Does the patient have a history of seizures?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
6. Is the patient currently ambulatory, with minimal walking impairment or use of cane, crutch or brace?	<input type="checkbox"/> Y <input type="checkbox"/> N
[No further questions.]	
7. Has the patient experienced improvement in functionality, activities of daily living and other relevant clinical measures?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
8. Has the patient demonstrated a 20% improvement from baseline in timed walking speed (timed 25 foot walk)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

<b>Prescriber (Or Authorized) Signature and Date</b>