PRIOR AUTHORIZATION FORM

AMPYRA®

Anthem HealthKeepers
Offered by HealthKeepers, Inc.

Requests for prior authorization (PA) must include patient name, Medicaid ID #, drug name and appropriate clinical information to support the request on the basis of medical necessity. Please include all requested information; incomplete forms will delay the PA process.

The completed form may be faxed to **1-844-512-7020**.

All questions must be answered.

Today's Date: ___ ___/___ ___/___ ___ ___ ___ Requested Start Date: ___ ___/___ ___/___ ___ ___ ___

PATIENT INFORMATION	
Name: (Last, First) _____ **Medicaid ID#:** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	
Date of Birth: ___ ___/___ ___/___ ___ ___ ___ **Gender:** □ **Male** □**Female**	
DRUG INFORMATION	
Drug Name/ Form: _____ **Strength:** _____	
Dosing Frequency: _____ **Length of Therapy:** _____	
DIAGNOSIS AND MEDICAL INFORMATION	
Does the patient have a diagnosis of Multiple Sclerosis (ICD-9 code = 340)?	☐ **Yes** ☐ **No**
If no above, please provide diagnosis. Diagnosis: _____	
Does the patient have a gait disorder or difficulty walking?	☐ **Yes** ☐ **No**
Does the patient have a history of seizures?	☐ **Yes** ☐ **No**
Does the patient have moderate to severe renal impairment (Creatinine Clearance [CrCL] ≤ 50 mL/min.)?	☐ **Yes** ☐ **No**
What is the patient's baseline Timed 25-foot Walk and date? _____	
If continuation of Ampyra® therapy, what is the current Timed 25-Foot Walk?	
Current Timed 25-Foot Walk: _____ **Date of Timed 25-Foot Walk:** _____	
List pharmaceutical agents attempted and outcome:	
1.	
2.	
Medical necessity: Provide clinical evidence that the preferred agent(s) will not provide adequate benefit:	
PRESCRIBER INFORMATION	
Name (print):_____ **NPI Number:** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	
Phone Number: (___ ___ ___) ___ ___ ___-___ ___ ___ ___ **Fax Number:** (___ ___ ___) ___ ___ ___-___ ___ ___ ___	
Signature of Prescribing Provider: _____	
PLEASE INCLUDE ALL REQUESTED INFORMATION. **INCOMPLETE FORMS WILL DELAY THE PRIOR AUTHORIZATION PROCESS.**	

FAX TO 1-844-512-7020.
PRIOR AUTHORIZATION CRITERIA IS SUBJECT TO CHANGE.