

**Physician's Prior Authorization Questionnaire
Ampyra™ (dalfampridine)**

Patient:

ID#:

DOB:

Patient Address:

Ampyra™ (dalfampridine) is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

If coverage for Ampyra™ is approved, the initial coverage time will only be for 12 weeks. After 12 weeks, attestation of benefit to the patient as measured by an increase in walking speed must be provided for continuation of coverage. If the patient has responded, coverage will be approved every 6 months as long as the patient is still benefiting and is still ambulatory.

Is this an initial request for coverage? Yes No

If Yes, answer questions 1 thru 4 only and submit this form.

Is this a request for continuation of coverage? Yes

If Yes, answer questions 5 and 6 only and submit this form.

1. Does the patient have a diagnosis of Multiple Sclerosis? Yes No
2. Is the patient ambulatory? Yes No
3. Does the patient have a history of seizures? Yes No
4. Has the patient undergone a timed 25 foot walk to establish a baseline walking speed? Yes No
5. Has the patient responded to an initial 12 week trial of Ampyra™ as demonstrated by a faster timed 25 foot walk trial compared to the baseline measurement? Yes No
6. Is the patient still ambulatory? Yes No

Ampyra™ will be shipped to the patient from our Specialty Pharmacy.

Physician's Signature

Date

Please **Print** Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.