Prior Authorization Request

Nevada Medicaid – Molina Healthcare

Multiple Sclerosis – Ampyra®

Please provide the information below. Please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **FAX responses to: (844) 259-1689. Phone: (833) 685-2103**

DATE OF REQUEST:

MEMBER INFORMATION

Last name, First name, Middle initial:		Date of birth:
Molina ID:	Gender: ☐ Male ☐ Female	Phone:

PRESCRIBING PROVIDER INFORMATION

Name:	NPI:
Phone:	Fax (required):
Person to contact regarding this request:	

DIAGNOSIS AND REQUESTED DRUG

Applicable diagnosis **or** symptom/side effect **(REQUIRED)**:

Name: **Ampyra®**	Strength:
Dosage:	Duration:

This request is for *(check one)*: ☐ Initial therapy ☐ Continuing therapy

COVERAGE CRITERIA

The following criteria must be met <u>and</u> documented in the recipient's medical record.

Check the applicable boxes to indicate each item as true for the recipient:

- ☐ The prescriber is a neurologist.
- ☐ The recipient has a diagnosis of Multiple Sclerosis.
- ☐ Ampyra is being requested to improve walking (FDA-approved indication).
- ☐ The recipient is ambulatory and has an Expanded Disability Status Scale (EDSS) score between 2.5 and 6.5.
- ☐ The recipient does not have moderate to severe renal dysfunction (creatinine clearance < 50 ml/min).
- ☐ The recipient does not have a history of seizures.
- ☐ The recipient is not pregnant or attempting to conceive.

Continuing therapy only:

- ☐ The recipient still meets initial criteria.
- ☐ The recipient has demonstrated an improvement in timed walking speed of ≥ 20% on Ampyra®.

PROVIDER CERTIFICATION – *Prescriber's signature and date required.*

I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.

Prescriber's Signature:____Date: ____________________

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.