



**AMPYRA (dalfampridine)
PRIOR REVIEW/CERTIFICATION FAXBACK FORM**

INCOMPLETE FORMS MAY DELAY PROCESSING

ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT BCBSNC PROVIDER ID# BELOW

PRESCRIBER INFORMATION		PATIENT INFORMATION	
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME	
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID	
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH	
PRACTICE ADDRESS	CITY	STATE	ZIP

Dx Code: _____

Please check the appropriate box to indicate if this request is for initial coverage or for continuation of current coverage and answer the corresponding questions.

Initial Coverage¹

1. Does the patient have a diagnosis of multiple sclerosis (any type)? Yes No
2. Is the patient ambulatory (able to walk with or without assistance)? Yes No
3. Has a baseline 25-foot walking test been performed? Yes No
 a. For the baseline walk test, how many seconds did it take for the patient to walk 25 feet? _____
4. Does the patient have a history of seizures? Yes No
5. Does the patient have moderate to severe renal impairment (CrCl < 50 ml/minute)? Yes No

¹Initial approvals are for a four-month period.

Continued Coverage² (patient is taking Ampyra)

1. Date that patient started therapy with Ampyra: _____
2. Has the patient demonstrated at least a 20% improvement in their ability to walk 25 feet? Yes No
 a. For the follow-up walk test, how many seconds did it take for the patient to walk 25 feet? _____

²After the initial coverage period, coverage will be provided for an indefinite period of time, if approved.

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): _____ Date: _____

For BCBSNC members, fax form to 1-800-795-9403