Prescriber Criteria Form

Ampyra 2025 PA Fax 477-A v1 010125.docx
Ampyra (dalfampridine)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Ampyra (dalfampridine).

Drug Name:
Ampyra (dalfampridine)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of multiple sclerosis (MS)? [If no, then no further questions.]	Yes ◯	No ◯
2	Is the patient currently being treated with the requested drug? [If yes, then skip to question 4.]	Yes ◯	No ◯
3	Prior to initiating treatment with the requested drug, did the patient demonstrate sustained walking impairment? [No further questions.]	Yes ◯	No ◯
4	Has the patient experienced an improvement in walking speed or other objective measure of walking ability since starting treatment with the requested drug?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____