

Prior Authorization Request
Nevada Medicaid – OptumRx
Multiple Sclerosis – Ampyra®

Submit fax request to: 855-455-3303

Purpose: For a prescribing physician (neurologist) to request prior authorization for Ampyra®.

Questions: If you have questions, call the OptumRx Call Center for Nevada Medicaid at 855-455-3311.

DATE OF REQUEST:		
RECIPIENT INFORMATION		
Last name, First name, Middle initial:		Date of birth:
Recipient ID:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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 (<i>check one</i>): <input type="checkbox"/> Initial therapy <input type="checkbox"/> 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:		
<input type="checkbox"/> The prescriber is a neurologist.		
<input type="checkbox"/> The recipient has a diagnosis of Multiple Sclerosis.		
<input type="checkbox"/> Ampyra is being requested to improve walking (FDA-approved indication).		
<input type="checkbox"/> The recipient is ambulatory and has an Expanded Disability Status Scale (EDSS) score between 2.5 and 6.5.		
<input type="checkbox"/> The recipient does not have moderate to severe renal dysfunction (creatinine clearance < 50 ml/min).		
<input type="checkbox"/> The recipient does not have a history of seizures.		
<input type="checkbox"/> The recipient is not pregnant or attempting to conceive.		
<i>Continuing therapy only:</i>		
<input type="checkbox"/> The recipient still meets initial criteria.		
<input type="checkbox"/> 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.