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: ☐ 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 and 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:** _____