Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Dalfampridine

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is this a renewal request? If yes, go to 9 If not, go to 2

☐ Yes ☐ No

Q2. Does the patient have a confirmed diagnosis of multiple sclerosis?

☐ Yes ☐ No

Q3. Is the patient prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q4. Does the patient have any contraindications to the prescribed drug?

☐ Yes ☐ No

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Is the medication being prescribed by or in consultation with a neurologist?

☐ Yes ☐ No

Q7. Is there documentation attached showing that dalfampridine is being used to improve walking? Please include chart notes.

☐ Yes ☐ No

Q8. Is there documentation attached showing that the member is ambulatory and has experienced sustained walking impairment, defined as ONE of the following? a. 25-foot timed walk completed within 8 to 45 seconds; b. For a 25-foot timed walk less than 8 seconds, the Expanded Disability Status Scale (EDSS) must be between 4.0 and 6.5

☐ Yes ☐ No

Q9. For reauthorization, is the patient prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q10. Has the patient experienced an improvement in timed walking speed (T25FW) of at least 10% from baseline?

☐ Yes ☐ No

Q11. Additional Information:

_____ _____

Prescriber Signature Date

v2025