



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: <input type="checkbox"/> 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.

<p>Q1. Is this a request for reauthorization? [If YES, go to 9. If NO, go to 2]</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q2. Does the patient have a confirmed diagnosis of multiple sclerosis?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. Is the patient prescribed a dose and duration of therapy consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q4. Does the patient have any contraindications to the prescribed drug?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. Is the patient 18 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



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Patient Name:	Prescriber Name:
Q6. Is the medication being prescribed by or in consultation with a neurologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Are chart notes attached showing that dalfampridine is being used to improve walking? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Are chart notes attached showing that the member is ambulatory and has experienced sustained walking impairment, defined as ONE of the following? <input type="checkbox"/> a. 25-foot timed walk completed within 8 to 45 seconds <input type="checkbox"/> 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	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. Has the patient experienced an improvement in timed walking speed (T25FW) of at least 10% from baseline? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q11. Additional Information:	

Prescriber Signature

Date

v2026