Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Ampyra

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners 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:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP:	
	Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

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 the prescribing physician a Neurologist?
☐ Yes ☐ No

Q2. Is the patient greater than or equal to 18 years of age with a diagnosis of multiple sclerosis?
☐ Yes ☐ No

Q3. Is the patient's Kurtzke Expanded Disability Status Scale (EDSS) score* provided/attached?
☐ Yes ☐ No

Q4. What is the patient's Kurtzke Expanded Disability Status Scale (EDSS) score?

Q5. Is the patient able to walk 25 feet in 8 to 45 seconds?
☐ Yes ☐ No

Q6. How long did it take the patient to walk 25 feet?

Q7. Does the patient have history of a seizure disorder?
☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q8. Does the patient have normal renal function (CrCL greater than 50 mL/min)?

☐ Yes ☐ No

Q9. Will the patient be receiving concomitant treatment with a disease-modifying agent (e.g. Avonex, Copaxone, Glatopa, Aubagio, Tecfidera)?

☐ Yes ☐ No

Q10. Is the dose and frequency of treatment prescribed within medically accepted guidelines for use and does not exceed 10 mg twice daily?

☐ Yes ☐ No

Q11. Requested Duration:

☐ 3 months

Q12. Additional Information:

Prescriber Signature

Date

Updated 2018