

UPMC HEALTH PLAN

AMPYRA

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-979-UPMC (8762)

FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:			
Provider First Name:		Provider Last Name:			
Provider Phone:		Provider Fax:		Provider NPI #:	
Patient Name:		Patient UPMC Health Plan ID Number:		Patient DOB:	
Drug Requested:	Strength:	Frequency:	Qty Dispensed:	Patient Age:	
<i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i>					
<input type="checkbox"/> New Medication	If Ongoing Provide Date Started:	If medication is ongoing, did the member show improvement while on therapy?			<input type="checkbox"/> Yes
<input type="checkbox"/> Ongoing Medication					<input type="checkbox"/> No
Diagnosis:				Date of Diagnosis:	
Please indicate place of administration:		<input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Clinic		Will the drug be: (select one) <input type="checkbox"/> Billed directly by the provider via JCODE JCODE: _____ <input type="checkbox"/> Billed by a pharmacy and delivered to the provider <input type="checkbox"/> Billed by a pharmacy and delivered to the patient	
Please provide hospital/facility name and address:					

MEDICAL HISTORY

Does the member have a diagnosis of Multiple Sclerosis? If no, please provide diagnosis:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is Ampyra being prescribed by or in consultation with a Neurologist?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Please submit chart documentation in the form of a recent progress note showing the member's baseline motor disability		<input type="checkbox"/> Documentation enclosed <input type="checkbox"/> Documentation not available	
Is the member currently taking any other forms of 4-aminopyridine?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the member have a history of seizures?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the member have moderate or severe renal impairment (CrCL less than or equal to 50 mL/min)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please provide any additional information which should be considered in the space below:
