

AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

AMPRYA®

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

PATIENT INFORMATION

Last Name:

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First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Medicaid ID Number:

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Date of Birth:

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Gender: Male Female

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

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First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

NPI Number:

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Phone Number:

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Fax Number:

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DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Patient's Last Name:

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Patient's First Name:

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DIAGNOSIS AND MEDICAL INFORMATION

Does the patient meet the following criteria?

1. Does the patient have a diagnosis of Multiple Sclerosis (ICD-10 = G35)?

Yes No If **No**, provide diagnosis: _____

2. Does the patient have a gait disorder or difficulty walking?

Yes No

3. Does the patient have a history of seizures?

Yes No

4. Does the patient have moderate to severe renal impairment (Creatinine Clearance [CrCL] ≤ 50 mL/min.)?

Yes No

5. What is the patient's **baseline** Timed 25-foot Walk and date?

Baseline Timed 25-Foot Walk: _____ **Date of Timed 25-Foot Walk:** _____

6. If continuation of Ampyra® therapy, what is the **current** Timed 25-Foot Walk?

Current Timed 25-Foot Walk: _____ **Date of Timed 25-Foot Walk:** _____

7. List pharmaceutical agents attempted and outcome:

8. **Medical Necessity:** Provide clinical evidence that the preferred agent will not provide adequate benefit:

Prescriber Signature (Required)

Date

By signature, the Physician confirms the above information is accurate and verifiable by patient records.

Please include ALL requested information; Incomplete forms will delay the PA process. Submission of documentation does NOT guarantee coverage.