



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Ampyra

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

HEALTH PARTNERS 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 left blank or illegible may delay the review process.**

Patient Name:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

Patient belongs to (please check one): HEALTH PARTNERS

KIDZPARTNERS

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:

Q1. What is the duration of the therapy requested?

6 months or less More than 6 months

Q2. Does the patient have an improvement in timed walking speed (T25FW) from baseline?

Yes No

Q3. Please provide time.

Q4. Is the dose and frequency of treatment prescribed within medically accepted guidelines for use and does not exceed 10 mg twice daily?

Yes No

Q5. Comments:

Q6. Deliver to:

Physician's Office Home

Q7. Delivery date needed:

Physician Signature

Date