



Date of Request: _____

Sterling Retiree Rx Prior Authorization Form

AMPYRA

Coverage Criteria / Required Medical Information:

Patient must be able to walk 25 feet with or without assistance.

Patient must demonstrate sustained walking impairment prior to starting Ampyra. To continue therapy, the patient must experience an improvement in walking speed or other objective measure of walking ability since starting Ampyra.

Coverage Duration: 2 months, then plan year upon renewal

Exclusion Criteria: Moderate to severe renal impairment, history of seizures, Ampyra at doses exceeding 10 mg twice daily.

Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physician Information

Name					
Agent			Contact Name		
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone			Fax		

Requested Drug

AMPYRA		Reason for Request			
Condition/Diagnosis Related					

Clinical Drug/Lab History Pertinent to Request

Labs: Baseline/Ongoing			Strength/Dosage		
Formulary Alternative(s) Attempted?		Yes:		No:	
Please List Alternative Formulary Drugs					

Comments	
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Physician Signature: _____

Fax Form to 1-866-481-3704