

ONLY the prescriber may complete this form.

The following documentation is **REQUIRED** for prior authorization. Incomplete forms will be returned for additional information. For formulary information, please visit the Blue Cross and Blue Shield of Kansas Web site at www.bcbsks.com

PATIENT INFORMATION

Today's Date: _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip	Patient Telephone:	

INSURANCE INFORMATION

BCBS ID Number:	Group Number:
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PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Medication Requested: AMPYRA 10mg	Dosing Schedule:
All patients	
1. Is the prescriber a neurologist or has Ampyra therapy been recommended by a neurologist via consult? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. What is the patient's diagnosis? <input type="checkbox"/> Relapsing Remitting Multiple Sclerosis <input type="checkbox"/> Primary Progressive Multiple Sclerosis <input type="checkbox"/> Secondary Progressive Multiple Sclerosis <input type="checkbox"/> Other: _____	
3. Is concurrent therapy with a disease modifying agent indicated in this patient? <input type="checkbox"/> Yes <input type="checkbox"/> No (i.e.: Avonex, Betaseron, Copaxone, Extavia, Gilenya, Novantrone, Rebif, or Tysabri) If yes, is the patient receiving concurrent therapy with a disease modifying agent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Does the patient have a history of seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. What is the patient's creatinine clearance (reported as CrCl, not eGFR) _____ mL/min	
Initial Therapy	
6. Is the patient ambulatory? <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. If yes, what is the patient's baseline timed 25 foot walk? _____ seconds	
Renewal Therapy	
8. What is the patient's current timed 25 foot walk? _____ seconds	
9. Please list all reasons for selecting the requested strength, dosing schedule and quantity over alternatives (e.g. lower dose has been tried.) _____	

This optional prescription order form can be used for Triessent Specialty Pharmacy (888-216-6710)

Medication	Form	Qty	Directions/Freq	Refills
Ampyra™	10mg tablet			

I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature Required: _____ **Date:** _____

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
1305 Corporate Center Drive
Eagan, Minnesota 55121
TOLL FREE
Fax: 877.480.8130 **Phone:** 866.469.5660

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