CVS CAREMARK

Fax Referral To: 800-323-2445

Phone: 866-278-6634

Ampyra® (dalfampridine)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Contact Phone: _____

INSURANCE INFORMATION *(If available, please copy and attach the front and back of insurance and prescription drug card)*

Primary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI**

Secondary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 Code): ☐ _____ • Date of Diagnosis: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas that are not filled out will be considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

- Does the patient have a history of seizures? ☐ Yes ☐ No
- Is the patient's CrCl ≤ 50 mL/minute? ☐ Yes ☐ No
- Does the patient have a diagnosis of multiple sclerosis? ☐ Yes ☐ No
- Does the patient require a wheelchair for mobility? ☐ Yes ☐ No
- Does the patient have sustained walking impairment? ☐ Yes ☐ No
- What is the result of the patient's pre-treatment timed 25-foot walk (T25FW) test?
- Is the patient currently on treatment with Ampyra and received at least 3 months of treatment? ☐ Yes ☐ No
  - If yes, what is the current T25FW results?

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Ampyra (dalfampridine)				

_____ _____

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)