UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2018 P 1005-7
Program	Prior Authorization/Notification
Medication	Ampyra® (dalfampridine)
P&T Approval Date	5/2010, 5/2011, 5/2012, 5/2013, 5/2014, 5/2015, 5/2016, 5/2017, 5/2018
Effective Date	8/1/2018; Oxford only: 8/1/2018

1. Background:

Ampyra® (dalfampridine) is a potassium channel blocker indicated to improve walking in patients with multiple sclerosis (MS). This was demonstrated by an increase in walking speed.[1]

2. Coverage Criteria:

A. <u>Initial Authorization</u>

1. **Ampyra** will be approved based on **both** of the following criteria:

   a. Diagnosis of multiple sclerosis

   -AND-

   b. Physician confirmation that patient has difficulty walking (e.g. Timed 25-foot Walk)

   Authorization will be issued for 6 months.

B. <u>Reauthorization</u>

1. **Ampyra** will be approved based on the following criteria:

   a. Physician confirmation that the patient's walking improved with Ampyra therapy

   Authorization will be issued for 12 months.

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3. Additional Clinical Programs:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Ampyra [package insert]. Acorda Therapeutics, Inc. Ardsley, NY. September 2017.

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Change Control	
5/2014	Annual review with no change to criteria.
5/2015	Annual review with no changes to clinical criteria. Deleted educational statement and updated references.
5/2016	Annual review. Updated criteria to require only a diagnosis. Updated references.
5/2017	Annual review with no changes to criteria.
5/2018	Annual review with no changes to clinical criteria. Updated references.
12/2018	Administrative change to add statement regarding use of automated processes.

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