



Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/chp-forproviders/pharmacy

Dalfampridine Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification to support diagnosis

Member Information					
Member Name (first & last):	Date of Birth:	Gender:		Height:	
		<input type="checkbox"/> Male	<input type="checkbox"/> Female		
Member ID:	City:	State:		Weight:	
Prescribing Provider Information					
Provider Name (first & last):	Specialty:	NPI#	DEA#		
Office Address:	City:	State:	Zip Code:		
Office Contact:	Office Phone		Office Fax:		
Dispensing Pharmacy Information					
Pharmacy Name:	Pharmacy Phone:		Pharmacy Fax:		
Requested Medication Information					
Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): Yes No	Diagnosis:		ICD-10 Code:		
Are there any contraindications to formulary medications? If yes, please specify:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> New request	<input type="checkbox"/> Continuation of therapy request	
Directions for Use:	Strength:		Dosage Form:		
	Quantity:	Day Supply:	Duration of Therapy/Use:		
What medication(s) has the member tried and failed for this diagnosis? Please specify below.					
Turn-Around Time for Review					
<input type="checkbox"/> Standard – (24 hours)	<input type="checkbox"/> Urgent – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____				
Clinical Information					
Does member have an impaired walking ability defined as baseline 25-foot walking test between 8 AND 45 seconds?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have an expanded Disability Status Scale between 4.5 AND 6.5?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is member wheelchair bound?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have history of seizures?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has there been disease exacerbation in previous 60 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have moderate to severe renal impairment (CrCl < 50 mL/min)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal Request ONLY					
Was there improvement in timed walking speed on 25-foot walk?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there stability or improvement in Expanded Disability Status Scale score?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does member have moderate to severe renal impairment CrCl <50 mL/min)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was an annual Electroencephalography test completed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.					

[Empty box for chart notes]

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ Date: _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.
Standard turnaround time is 24 hours. You can call 833-711-0776 to check the status of a request.