AMPYRA

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
<th>Length of Authorization</th>
</tr>
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<tbody>
<tr>
<td>Ampyra</td>
<td>dalfampridine ER</td>
<td>Per Medical Guidelines</td>
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</tbody>
</table>

**Approvable Criteria**

1. Is Ampyra prescribed by a neurologist?
   - If yes, continue to #2.
   - If no, do not approve.

2. Does the member have a diagnosis of Multiple Sclerosis (MS) and documented Timed 25-Foot Walk (T25FW) Test between 8-45 seconds OR an Expanded Disability Status Scale (EDSS) score between 3.0-6.0?
   - If yes, continue to #3.
   - If no, do not approve.

3. Does the member have moderate to severe renal impairment as evidenced by CrCl ≤ 50 mL/minute?
   - If yes, do not approve.
   - If no, continue to #4.

4. Does the member have a history of seizures?
   - If yes, do not approve.
   - If no, continue to #5.

5. Is the member currently receiving disease-modifying therapy for MS (i.e. Avonex, Betaseron, Extavia, Copaxone, Rebif, Tysabri, or Novantrone)?
   - If yes, continue to #6.
   - If no, do not approve.

6. Is this request for initial therapy or retreatment?
   - For initial therapy, approve for 4 months.
   - For retreatment, approve for Calendar year if clinical documentation is provided reflecting a 20% improvement in timed walking speed or EDSS score from baseline with Ampyra therapy.

**QL = 60 x 30 DAYS**

**SPECIALTY PHARMACY PRODUCT**

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*References:*
