



**Department of Vermont Health Access
 MULTIPLE SCLEROSIS ORAL MEDICATIONS
 PRIOR AUTHORIZATION REQUEST**

PATIENT INFORMATION

Last Name		First Name	Middle Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID#	
Allergies: <input type="checkbox"/> NKA or _____			
Street Address		City	
State	County	Zip Code	
Home Phone		Cell Phone	
Parent/Guardian	Day Telephone	Night Telephone	
Emergency Contact	Relationship	Telephone	

PRESCRIBER'S INFORMATION

Prescriber's Name		NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name	
Street Address		City	
State	County	Zip Code	
Contact Person at Office		Prescriber Specialty	

Please Fax Completed for to:
Fax Number 1-800-218-3221
Phone Number 1-866-843-3604



Patient Diagnosis:

Does the patient have relapsing forms of multiple sclerosis (including relapsing-remitting multiple sclerosis and progressive-relapsing multiple sclerosis)? Yes No

Prescriber Additional Comments:

PRESCRIPTION

Ampyra (Dalfampridine) 10mg tablet Dispense Quantity 60
 Sig: Take one tablet by mouth twice daily Refill X: _____

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

Last Updated: 11/2016