Ampyra (dalfampridine) is a preferred product and will only be considered for coverage under the pharmacy benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

### SYMPTOM MANAGEMENT: WALKING (GAIT) DIFFICULTIES

For **initial** authorization:
1. Member must be age 18 or older; AND
2. Medication must be prescribed by, or in consultation with, or under the guidance of a neurologist; AND
3. Member has been on a disease modifying agent (Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Copaxone (glatiramer acetate), Extavia (interferon beta-1b), Glatopa (glatiramer acetate), Plegridy (peginterferon beta-1a), Rebif (interferon beta-1a), Zinbryta (declizumab), Aubagio (teriflunomide), Gilenya ( fingolimod), Tecfidera (dimethyl fumarate), Lemtrada (alemtuzumab), Novantrone (mitoxantrone), Tysabri (natalizumab), Ocrevus (ocrelizumab)) for at least the last 90 days; AND
4. Member is ambulatory and has documented baseline of the timed 25 foot walk (T25FW) between 8 and 45 seconds.
5. **Dosage allowed**: 10 mg every 12 hours.

**If member meets all the requirements listed above, the medication will be approved for 6 months.**

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Documentation of member’s increase in walking speed submitted with chart notes.

**If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.**

CareSource considers Ampyra (dalfampridine) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Acute spinal cord injury
- Disorder of neuromuscular transmission
07/18/2017 | New policy for Ampyra created. Not covered diagnosis added.

References:

Effective date: 08/09/2017
Revised date: 07/18/2017