DIVISION OF HEALTH CARE FINANCING AND POLICY
NEVADA MEDICAID
DRUG USE REVIEW (DUR) BOARD

PROPOSED PRIOR AUTHORIZATION CRITERIA

Class Name: Multiple Sclerosis Agents: Miscellaneous Oral Agents for Symptoms

Generic Name: Dalfampridine

Brand Name: Ampyra™

Coverage and Limitations:

Ampyra™ (Dalfampridine) is a covered benefit of Nevada Medicaid for recipients who meet ALL of the following criteria for coverage.

1. Criteria for Approval:

   A. Prescriber is a neurologist AND

   B. Patient has a diagnosis of Multiple Sclerosis (ICD-9 code of 340) AND

   C. Use is for the FDA Approved Indication:

      a. To improve walking AND

   D. Patient is ambulatory and has an EDSS score between 2.5 and 6.5 AND

   E. Patient has undergone a timed 25 foot walk to establish baseline walking speed and baseline walking speed is between 8 and 45 seconds AND

   F. Patient does not have moderate to severe renal dysfunction (CrCL > 50 ml/min) AND

   G. Patient does not have a history of seizures AND

Initial Approval Duration: 12 weeks

2. Criteria for Renewal:

   A. Patient still meets ALL initial approval criteria AND

   B. Patient has demonstrated an improvement in timed walking speed of at least 20% on Ampyra.

Duration: 1 year

Quantity Limit: #60 10 mg tablets per 30 days