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

Ampyra® (dalfampridine) is a covered benefit of Nevada Medicaid for recipients who meet the following criteria for coverage.

1. Coverage and Limitations:
Authorization will be given if the following criteria are met and documented:

Requests for Ampyra® (dalfampridine)

1. Must have ALL of the following:
    a. The recipient has a diagnosis of multiple sclerosis.
    AND
    The requested medication is being used to improve the member's walking speed.
    AND
    The medication is being prescribed by or in consultation with a neurologist.
    AND
    The recipient is ambulatory and has an EDSS score between 2.5 and 6.5.
    AND
    The recipient does not have moderate to severe renal dysfunction (CrCL >50ml/min).
    AND
    The recipient does not have a history of seizures.
    AND
    The recipient is not currently pregnant or attempting to conceive.

2. PA Guidelines:
Initial prior authorization approval will be for 3 months
Requests for continuation of therapy will be approved for 1 year

3. Quantity Limitations:
60 tablets per 30 days