UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

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| Program Number | 2024 P 1005-13 |
| Program | Prior Authorization/Notification |
| Medication | Ampyra® (dalfampridine) |
| P&T Approval Date | 5/2010, 5/2011, 5/2012, 5/2013, 5/2014, 5/2015, 5/2016, 5/2017, 5/2018, 5/2019, 5/2020, 5/2021, 5/2022, 5/2023, 5/2024 |
| Effective Date | 8/1/2024 |

**1. Background:**
Ampyra® (dalfampridine) is a potassium channel blocker indicated to improve walking in patients with multiple sclerosis (MS). This was demonstrated by an increase in walking speed.[1]

**2. Coverage Criteria[a]:**

**A. Initial Authorization**

1. **Ampyra** will be approved based on **both** of the following criteria:

   a. Diagnosis of multiple sclerosis

   **-AND-**

   b. Physician confirmation that patient has difficulty walking (e.g., Timed 25-foot Walk)

   **Authorization will be issued for 12 months.**

**B. Reauthorization**

1. **Ampyra** will be approved based on the following criteria:

   a. Physician confirmation that the patient's walking improved with Ampyra therapy

   **Authorization will be issued for 12 months.**

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

**3. Additional Clinical Programs:**

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

**4. References:**

1. Ampyra [package insert]. Acorda Therapeutics, Inc. Ardsley, NY. June 2022.

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| **Change Control** | |
| 5/2014 | Annual review with no change to criteria. |
| 5/2015 | Annual review with no changes to clinical criteria. Deleted educational statement and updated references. |
| 5/2016 | Annual review. Updated criteria to require only a diagnosis. Updated references. |
| 5/2017 | Annual review with no changes to criteria. |
| 5/2018 | Annual review with no changes to clinical criteria. Updated references. |
| 12/2018 | Administrative change to add statement regarding use of automated processes. |
| 5/2019 | Annual review with no changes to clinical criteria. |
| 5/2020 | Annual review with no changes to clinical criteria. Updated reference. |
| 5/2021 | Annual review with no changes to clinical criteria. |
| 5/2022 | Annual review with no change to clinical criteria. Updated reference. |
| 5/2023 | Annual review with no change to clinical criteria. Added state mandate footnote. Updated reference. |
| 5/2024 | Annual review. Initial Authorization increased to 12 months. |