VENTURA COUNTY
HEALTH CARE PLAN

FORMULARY EXCEPTION POLICY

POLICY: Multiple Sclerosis – Ampyra® (dalfampridine extended-release tablets – Acorda Therapeutics)

DATE CREATED: 7/1/2019

Documentation: Documentation will be required for patients requesting brand Ampyra where noted in the criteria as [documentation required]. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts and/or laboratory data.

CRITERIA

1. **Multiple Sclerosis (MS).** Approve for 1 year if the patient meets the following criteria (A, B and C):
   - **A)** Ampyra is being used to improve mobility in a patient with MS; AND
   - **B)** Ampyra is being prescribed by, or in consultation with, a neurologist or a physician who specializes in the treatment of MS; AND
   - **C)** The patient meets both of the following criteria (i and ii):
     - **i.** The patient has tried generic dalfampridine **[documentation required]**; AND
     - **ii.** Brand Ampyra is being requested due to a formulation difference in the inactive ingredient(s) [e.g., differences in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reactions **[documentation required]**.

ISTORY

Type of Revision	Summary of Changes*	Effective Date
New Policy	--	07/01/2019