145 The West Mall, P.O. Box 110 U
Toronto, ON M8Z 5M4

# PRIOR AUTHORIZATION PROGRAM FORM

## Fampyra ™ ( Fampridine )

**Instructions:**

1. Section 1 to be completed by Plan Member / Patient
2. Section 2 to be completed by Physician (expenses incurred by the completion of this form is at plan member's expense)
3. Section 3 to be completed by Pharmacist

Please fax completed form to NexgenRx Formulary Management to 1-877-639-4369 or mail to 145 The West Mall P.O. Box 110 U, Toronto, Ontario,M8Z-5M4

### Section 1: To be completed by Patient

| Member's Name: (Last , First ) | Card ID Number: | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patient's Name: (Last, First) | Patient's Date of Birth (dd/mm/yy) | Relationship to Member (please circle) Employee Spouse Dependent | PATIENT CODE | | |
|---|---|---|---|---|---|
| | | | | | |

**Results of this request to be communicated to:**

| ☐ Pharmacy | ☐ Patient / Legal Guardian Named Below | ☐ email: |
|---|---|---|

**I authorize NexgenRx Inc. (a) to use the personal information disclosed on this form, and any other personal information known to NexgenRx Inc. regarding the above-named patient, for the purpose of assessing this prior authorization request and any related claim and administering the benefit plan under which any such claim is made, and (b) to contact, and to obtain any such personal information from and to disclose any such personal information to, any physician, pharmacist or other health care professional having knowledge of such patient's health relevant to this request and any related claim.**

Patient / Legal Guardian Name: _____ Telephone Number: _____

Signature of Patient/ Legal Guardian: _____ Date (dd/mm/yy):_____

### Section 2: To be completed by Physician

| Drug Name & Strength: | DIN: | Dosage Instructions: |
|---|---|---|
| | | |

**Eligibility for drug coverage is dependent upon the patient meeting at least one of the qualifying criteria listed below. If the patient has another drug plan, prior authorization may cover some or all of the excess not paid by the primary plan.**

Please indicate if the patient meets the following qualifying criteria for drug coverage:

☐ Fampyra sustained release tablets are indicated for the symptomatic improvement of walking in adult patients with multiple sclerosis (MS) with walking disability (EDSS 3.5-7). The initial prescription should be for no more than 4 weeks, and assessment for improvement in walking should be carried out within that timeframe**.**

| Physician Name: (Last, First) | License Number: |
|---|---|
| Address: (Street, City, Province, Postal Code) | Telephone Number : ( ) -<br>Fax Number: ( ) - |
| Signature of Physician: | Date (dd/mm/yy) |

### Section 3: To be completed by Pharmacist

| Pharmacy Name: | Provider Number: |
|---|---|
| Pharmacy Address: (Street, City, Province, Postal Code) | Telephone Number : ( ) -<br>Fax Number: ( ) - |
| Signature of Pharmacist: _____<br>Pharmacist's Name: (Print Last, First) _____ | |

### Internal Office Use Only:

| Date Received: | | | Date Approved & By: |
|---|---|---|---|
| | | | |