PREFERRED SPECIALTY MANAGEMENT POLICY

POLICY: Multiple Sclerosis – Dalfampridine Preferred Specialty Management Policy
- Ampyra® (dalfampiridine extended-release tablets – Acorda/Alkeremes, generic)

REVIEW DATE: 10/26/2022

OVERVIEW

Dalfampridine is a potassium channel blocker that is indicated to improve walking in adults with multiple sclerosis.[1] This was demonstrated by an increase in walking speed.

POLICY STATEMENT

This Preferred Specialty Management program has been developed to encourage the use of the Preferred Product. For all medications (Preferred and Non-Preferred), the patient is required to meet the respective standard *Prior Authorization Policy* criteria. This program also directs the patient to try the Preferred Product prior to approval of a Non-Preferred Product. Requests for the Non-Preferred Product will also be reviewed using the exception criteria (below). All approvals are provided for 1 year in duration. If the patient meets the standard *Multiple Sclerosis – Dalfampridine Prior Authorization Policy* criteria but has not tried the Preferred Product, approval for a Preferred Product will be authorized.

Documentation: Documentation is required where noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, prescription claims records, and/or other information.

Automation: None

Preferred Product: generic dalfampridine
Non-Preferred Product: Ampyra

RECOMMENDED EXCEPTION CRITERIA

Non-Preferred Product	Exception Criteria
Ampyra	**1.** Approve for 1 year if the patient meets the following criteria (A and B): **A)** Patient meets the standard *Multiple Sclerosis – Dalfampridine Prior Authorization Policy* criteria; AND **B)** Patient meets both of the following (i and ii): **i.** Patient has tried generic dalfampridine **[documentation required]**; AND **ii.** Patient cannot continue to use generic dalfampridine due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. **2.** If the patient has met criterion 1A (the standard *Multiple Sclerosis – Dalfampridine Prior Authorization Policy* criteria), but criterion 1B is not met and the requested product is not approved, approve the Preferred Product.

REFERENCES

1. Ampyra® extended-release tablets [prescribing information]. Ardsley, NY: Acorda/Alkermes; November 2021.