

**1 STEP ONE: Complete Patient and Insurance Information (Please include copies of both sides of insurance card)**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Sex:  Male  Female DOB: \_\_\_\_\_ Email: \_\_\_\_\_ Last 4 digits of SS#: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  Cell Phone: \_\_\_\_\_  Alternate Phone: \_\_\_\_\_  
(Please check preferred phone number) Preferred time of day to call (between 8 AM - 8 PM ET): \_\_\_\_\_  
Caregiver (if applicable) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
ICD-9 code: 340 Multiple Sclerosis Type:  relapsing-remitting  primary progressive  secondary progressive  progressive relapsing  
Other (please specify): \_\_\_\_\_

Prescription Drug Insurer: \_\_\_\_\_  
BIN #: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name of Specialty Pharmacy for other medication(s): \_\_\_\_\_  
Primary Medical Insurance: \_\_\_\_\_ Cardholder Name: \_\_\_\_\_  
Relationship to Cardholder:  self  spouse  child  other ID # \_\_\_\_\_ Group #: \_\_\_\_\_ Phone: \_\_\_\_\_  
Secondary Medical Insurance: \_\_\_\_\_ Cardholder Name: \_\_\_\_\_  
Relationship to Cardholder:  self  spouse  child  other ID # \_\_\_\_\_ Group #: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient does not have insurance

**2 STEP TWO: Read and Sign Patient Authorization**

By signing this authorization, I authorize my health plans, physicians, and pharmacy providers to disclose my personal health information, including, but not limited to, information relating to my medical condition, treatment, care management, and health insurance, as well as information provided on this form and any prescription ("Personal Health Information"), to Acorda Therapeutics, Inc., and its representatives, agents, and contractors, including to Acorda's AMPYRA Patient Support Services Center operated by TheraCom LLC on behalf of Acorda (collectively "Acorda") for the following purposes: (1) to establish my eligibility for benefits; (2) to communicate with my health care providers and me about my medical care and the processing of my prescriptions by the AMPYRA Patient Support Services Center, my health plan, and my pharmacy providers; (3) to facilitate the provision of products, supplies or services by a third party including, but not limited to, specialty pharmacies; (4) to register me in any applicable product registration program required for my treatment; and (5) to evaluate the effectiveness of AMPYRA's education programs. I understand that once my Personal Health Information is disclosed under this authorization, it is no longer protected by Federal privacy laws and may be further disclosed by Acorda; however, Acorda agrees to protect my information and only use and disclose it for the purposes described above, or as I may further authorize in writing, or as required by law. I understand that my health care providers and insurance company may not condition my medical treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits on my signing of this authorization. I understand, however, that if I do not sign this authorization, I will not be able to receive assistance through the AMPYRA Patient Support Services Center. I understand that I am entitled to a copy of this authorization. I understand that I may cancel this authorization at any time by mailing a letter requesting such cancellation to Acorda Therapeutics, Inc., 9717 Key West Avenue, Rockville, MD 20850, but that this cancellation will not apply to any information already used or disclosed through this Authorization before notice of the cancellation is received by my health plans or health care providers. This authorization expires ten (10) years from the date signed below.

➔ Patient or Guardian Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

**I authorize Ampyra Patient Support Services Center to leave information regarding my Ampyra prescription, insurance coverage, and specialty pharmacy provider on my answering machine or voicemail.**

➔ Patient or Guardian Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

I further authorize the release of information provided in this enrollment form to Acorda for the provision of education, training, and ongoing support on the use of AMPYRA. Acorda may provide me with educational or product-related informational materials. TheraCom LLC, which operates the AMPYRA Patient Support Services Center for Acorda, may receive compensation from Acorda for providing such services. I authorize Acorda to contact me with promotional materials related to my treatment, to use and give out my information to send me information or materials related to AMPYRA or any other related products or services in which I might be interested, to contact me occasionally to obtain feedback (for market research purposes) about Acorda, AMPYRA, or the AMPYRA Patient Support Services Center, to operate (and improve the quality of) the AMPYRA program, or otherwise as required or permitted by law. If I do not wish to receive information related to AMPYRA or any related products or services or to be contacted occasionally for market research purposes, I understand that I may call the AMPYRA Patient Support Services Center's toll-free number, 888-881-1918 at any time.

➔ Patient or Guardian Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

➔ Patient First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

### 3 STEP THREE: Complete Prescriber Information

Prescriber's Name (First, Last): \_\_\_\_\_ Specialty: \_\_\_\_\_  
 Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Email: \_\_\_\_\_ NPI #: \_\_\_\_\_  
 Office Contact Name (First, Last): \_\_\_\_\_ Contact Phone: \_\_\_\_\_

➔  I authorize Ampyra Patient Support Services Center to contact patient directly to obtain patient signature.

### 4 STEP FOUR: Prescription (Please print, blue or black ink only.)

Rx: **AMPYRA (dalfampridine) Extended Release Tablets, 10 mg**

Sig: \_\_\_\_\_ Dispense:  60 tablets (30 day supply) Refills: \_\_\_\_\_  
 or  
 180 tablets (90 day supply) Refills: \_\_\_\_\_

I certify that this therapy is medically necessary and that this information is accurate to the best of my knowledge.

➔ Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### 5 STEP FIVE: Complete and Sign Physician Authorization

I authorize TheraCom LLC, as the operator of the AMPYRA Patient Support Services Center on behalf of Acorda Therapeutics, Inc ("TheraCom") to be my designated agent and to act as my business associate (as defined in 45 CFR 160.103) to use and disclose any information about any of my patients enrolled with the AMPYRA Patient Support Services Center to the insurer of such patients and to obtain any information about such patients, including any protected health information (as defined in 45 CFR 160.103), from the insurer, including eligibility and other benefit coverage information, for my payment and/or health care operation purposes. I authorize TheraCom to contact the patient to report coverage information and to inform them about the financial assistance programs offered by Acorda. TheraCom may de-identify any and all protected health information of my patients, provided that the de-identification complies with the requirements set forth in 45 CFR 164.514(b). As my business associate, TheraCom is required to comply with, and by its signature hereto, agrees that it will comply with, the applicable requirements of 45 CFR 164.504(e) regarding business associates, and that it will safeguard any protected health information that it obtains from me or on my behalf, and will use and disclose this information only for the purposes specified herein or as otherwise permitted by law.

➔ Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

TheraCom Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### 6 STEP SIX: Complete Clinical Information for Prior Authorization (Recommended)

Patient is Ambulatory  Patient has completed a baseline T25FW If yes, time in seconds: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Patient's EDSS Score, if available: \_\_\_\_\_

Patient is currently taking a Disease Modifying Therapy for MS:  Yes  No

History of Seizure:  Yes  No

Moderate or Severe Renal Impairment (CrCl ≤ 50 mL/min):  Yes  No

If unknown, **Creatinine Clearance (CrCl)** should be estimated prior to initiating treatment. Serum Creatinine: \_\_\_\_\_ mg/dL

Estimated CrCl calculated by:  $CrCl = \frac{(140 - age) \times weight (kg)}{SerumCr (mg/dl) \times 72} \times (0.85 \text{ for women})$ : \_\_\_\_\_ mL/min

Other Prior Authorization: \_\_\_\_\_

**Please fax both pages of the AMPYRA Patient Support Services Center Prescription & Service Request Form to:  
888-883-3053**

# What You Need to Do to Receive Your AMPYRA<sup>®</sup> Delivery



AMPYRA Patient Support Services Center will contact you to verify your insurance and co-pay amount. To verify your insurance and co-pay amount, **you must speak to the representative** who calls.

These calls may be from unrecognizable 800/888 phone numbers.



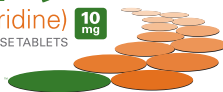
A Specialty Pharmacy will call to arrange your AMPYRA delivery. To receive your AMPYRA, **you must speak to the representative** who calls you to confirm your shipment.

These calls may be from unrecognizable 800/888 phone numbers.

**Have questions?** Call AMPYRA Patient Support Services toll-free 1-888-881-1918 Monday through Friday, from 8 AM to 8 PM ET.

ampyra<sup>®</sup>

(dalfampridine) 10 mg  
EXTENDED RELEASE TABLETS



AMPYRA<sup>®</sup> is a registered trademark of Acorda Therapeutics<sup>®</sup>, Inc.  
Ampyra<sup>®</sup> is marketed by Acorda Therapeutics<sup>®</sup>, Inc. and is manufactured under license from Elan Pharma International Ltd.  
The stylized Acorda logo is a registered trademark of Acorda Therapeutics<sup>®</sup>, Inc.  
The stylized path logo is a trademark of Acorda Therapeutics<sup>®</sup>, Inc.  
©2011 Acorda Therapeutics<sup>®</sup>, Inc. All rights reserved.