**This letter is only intended as a SAMPLE Letter of Medical Necessity
For AMPYRA® (dalfampridine) Extended Release Tablets, 10 mg**

**PLEASE USE PROVIDER’S LETTERHEAD**

Prescribing physician should edit the content of this
letter as appropriate for the subject patient

[XX/XX/XXXX]

[Insurance Company Name]

[Insurance Company Street Address]

[Insurance Company City], [Insurance Company State] [Insurance Company Zip Code]

 Re: Letter of Medical Necessity for:

[Patient Name]

[Patient Date of Birth]

[Policy ID#]

[Group#]

Dear Medical Director,

I am writing this letter to serve as formal documentation of the medical necessity of treatment with AMPYRA® (dalfampridine) Extended Release Tablets, 10 mg for my patient, [Patient Name], for [condition for which prescribed].

I prescribed AMPYRA based on my clinical evaluation of my patient and their medical history. The information below supports my assessment that the use of AMPYRA is both medically appropriate and necessary for my patient.

# Medical History:

[Patient’s medical history, diagnosis and current conditions]

# Treatment History:

[Prior treatments and response to those treatments]

It is my clinical opinion that AMPYRA is medically necessary to treat [Patient Name].

[Summarize basis for professional opinion that AMPYRA is medically necessary for the patient].

If you have any concerns about approving this necessary treatment for my patient, please contact my office at [Office Phone Number] and I will be happy to discuss further.

Sincerely,

[Physician’s name]

Use of this Sample Letter of Medical Necessity is not a guarantee of coverage. The information provided on this Form is not intended as legal advice or to replace a healthcare provider's professional medical judgement. It is the sole responsibility of the treating healthcare provider to confirm coverage and claims submission process with the patient's health insurance plan to help ensure AMPYRA claims are accurate, complete, and supported by appropriate documentation.