

AMPYRA® Patient Support Services Center

Prescription & Service Request Form

Fax completed form to 888-883-3053 Phone 888-881-1918

Please complete all fields to avoid any delays in processing.

Free 60 Day Trial



PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____ Sex: M F
Email: _____ Last 4 Digits of SSN: _____ DOB: _____
Address: _____ City: _____ State: _____ Zip: _____
Preferred Phone: _____ Alternate Phone: _____

INSURANCE INFORMATION

Prescription Drug Insurer: _____ ID #: _____ BIN #: _____ PCN #: _____
Group #: _____ Phone: _____ Preferred Specialty Pharmacy: _____
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

PATIENT AUTHORIZATION

I have read and agree to the attached **Patient Authorization Section A (Signature and Date Required)**.

X _____
Patient Signature *Date*

Initial Here The signature to the left also denotes that I authorize Ampyra Patient Support Services to leave information regarding my Ampyra prescription, insurance coverage, and Specialty Pharmacy Provider on my answering machine or voicemail (participation optional).

Initial Here The signature to the left also denotes that I have read and agree to the attached **Patient Marketing Consent Section B** (participation optional).

PRESCRIBER INFORMATION

FOR OFFICE USE ONLY

Prescriber's Name: _____ Specialty: Neurology Yes No Other: _____
Practice Name: _____ Phone: _____ Fax: _____
Address: _____ City: _____ State: _____ Zip: _____
Office Contact Name: _____ Contact Phone: _____ NPI #: _____

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

60 DAY TRIAL PRESCRIPTION

Free 60 Day Trial Enrollment

Patients with Medicaid, Medicare Part D, or other government funded coverage are not eligible. For eligibility requirements go to www.ampyra.com.

I request that Acorda provide two 60 count bottles of AMPYRA Extended Release Tablets, 10 mg.

Sig: **1 tab po q12h**

I certify that this therapy is medically necessary and that this is accurate to the best of my knowledge. (Signature and Date Required)

X _____
Prescriber Signature *Date*

PRESCRIPTION INFORMATION

Standard Continuing Prescription

Rx: AMPYRA Extended Release Tablets, 10 mg

Sig: **1 tab po q12h**

Other: _____

Dispense: 180 tablets (90 day supply) Refills: _____
 _____ Refills: _____

Indicate Diagnosis:

G35 Multiple Sclerosis
 Other: _____

I certify that this therapy is medically necessary and that this is accurate to the best of my knowledge. I authorize Labcorp Periapproval and Commercialization, Inc. and its affiliates ("Labcorp"), as the operator of Ampyra Patient Support Services on behalf of Acorda Therapeutics, Inc. ("Acorda"), to use and disclose the patient information herein contained to the patient's insurers and pharmacies and to obtain information, including any protected health information (as defined in 45 CFR § 160.103), from the patient, or from the patient's insurer or pharmacy, to facilitate dispensing as well as the patient's enrollment and participation in services offered by Ampyra Patient Support Services in a manner consistent with the HIPAA minimum necessary standard. I authorize Labcorp to contact the patient to report insurance coverage information, to inform the patient about the financial assistance programs offered by Acorda, and to obtain any patient consent(s) that may be necessary in order to support the patient's treatment with Ampyra as prescribed by me. I authorize Labcorp to transmit the above prescription to the pharmacy.

X _____
Prescriber Signature - Dispense As Written *Date*

Handwrite above as applicable by state: Date
Brand Medically Necessary/Dispense As Written/Do Not Substitute

Substitution Permitted *Date*

CLINICAL INFORMATION (recommended)

Patient is ambulatory Baseline T25FW _____ Seconds Date completed: _____
Patient's EDSS Score: _____ Concomitant Medications, if any: _____
History of Seizure: Yes No Patient Weight: _____ kg lbs Patient Allergies: _____
Moderate or Severe Renal Impairment: (CrCl ≤ 50 mL/min): Yes No Serum Creatinine: _____ mg/dL
Estimated CrCl: _____ mL/min. CrCl can be estimated using the following equation (multiply by 0.85 for women): CrCl = [(140-age) x weight (kg)]/[SerumCr (mg/dl) x 72]

Indication:

AMPYRA[®] (dalfampridine) is indicated to improve walking in adults with multiple sclerosis (MS). This was demonstrated by an increase in walking speed.

Important Safety Information:

- AMPYRA is contraindicated in patients with history of seizure, moderate or severe renal impairment (CrCl \leq 50 mL/min), or history of hypersensitivity to AMPYRA or 4-aminopyridine.
- AMPYRA can cause seizures. The risk of seizures increases with increasing doses. Permanently discontinue AMPYRA if seizure occurs. In the post-marketing period seizures have been reported. The majority of seizures occurred at the recommended dose, in patients without a history of seizures, and generally within days to weeks of starting therapy.
- AMPYRA has not been evaluated in patients with history of seizures or with epileptiform activity on an EEG, as these patients were excluded from clinical trials. The risk of seizures in patients with epileptiform activity on an EEG is unknown, and could be substantially higher than that observed in clinical studies.
- Avoid concomitant use of AMPYRA with other forms of 4-aminopyridine (4-AP, fampridine), since the active ingredient is the same. Instruct patients to discontinue use of any product containing 4-AP prior to initiating AMPYRA to reduce the potential for dose-related adverse reactions.
- AMPYRA can cause anaphylaxis and severe allergic reaction. Signs and symptoms included respiratory compromise, urticaria, and angioedema of the throat or tongue. If an anaphylactic or other serious allergic reaction occurs, permanently discontinue AMPYRA.
- AMPYRA is cleared predominantly by the kidneys. The risk of seizures in patients with mild renal impairment (CrCl 51–80 mL/min) is unknown, but AMPYRA plasma levels in these patients may approach those seen at a dose of 15 mg twice daily, a dose that may be associated with an increased risk of seizures. Estimated CrCl should be known before initiating AMPYRA and monitored at least annually during treatment.
- The most common adverse reactions (incidence \geq 2% and at a rate greater than placebo) for AMPYRA in MS patients were urinary tract infection, insomnia, dizziness, headache, nausea, asthenia, back pain, balance disorder, multiple sclerosis relapse, paresthesia, nasopharyngitis, constipation, dyspepsia, and pharyngolaryngeal pain.
- The risk of adverse reactions, including seizures, increases with increasing AMPYRA doses. There is no evidence of additional benefit at doses greater than 10 mg twice daily.
- Concomitant use with OCT2 inhibitors (e.g., cimetidine) may cause increased exposure to AMPYRA and potential risk of seizures.
- There are no adequate data on AMPYRA in pregnant women. Based on animal data, use of AMPYRA during pregnancy may cause fetal harm.
- There are no data on presence of AMPYRA in breastmilk; benefits of breastfeeding should be considered along with benefit of AMPYRA to the mother and potential risks to the infant.
- Safety and effectiveness of AMPYRA in patients younger than 18 years have not been established.
- Clinical studies of AMPYRA did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Because elderly patients are more likely to have decreased renal function, it is important to know the estimated CrCl before initiating AMPYRA.

Please see the Full Prescribing Information available at www.ampyra.com/prescribing-information.pdf



A. PATIENT AUTHORIZATION

By signing this authorization, I authorize my health plans, physicians, and pharmacies (collectively, my “Providers”) to disclose my personal health information relating to my medical condition, treatment, care management, and health insurance, as well as information provided on this form and any prescription (collectively, “Personal Health Information”), to Acorda Therapeutics, Inc. (“Acorda”) and its representatives, agents, and contractors, including but not limited to Acorda’s AMPYRA Patient Support Services Center operated by Labcorp Periapproval and Commercialization, Inc. and its affiliates on behalf of Acorda (collectively “the Entities”) for purposes of (1) providing services to me by the AMPYRA Patient Support Services Center; (2) facilitating the provision of products, supplies or services by Acorda; (3) registering me in any applicable Acorda product registration program; (4) evaluating the effectiveness of Acorda’s AMPYRA education programs and (5) enrolling me in Acorda’s Free 60 Day Trial, patient assistance program, copay mitigation program, or similar programs which may be deployed by Acorda (if one or more such programs apply to me). I understand that my pharmacies will disclose to the Entities certain personal health information regarding the dispensing of my Ampyra prescription and that such disclosure will result in remuneration to my pharmacies. I understand that once my Personal Health Information is disclosed to the Entities under this authorization, it is no longer protected by Federal privacy laws and may be further disclosed by the Entities. I understand that I may refuse to sign this authorization and my healthcare provider(s) and health plan(s) will not condition my treatment or benefits on whether I sign this Patient Authorization and Notice form. I understand, however, that if I do not sign this authorization, I may 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., PO Box 4280, Gaithersburg, MD 20885-4280, but that this cancellation will not apply to any information already used or disclosed pursuant to this authorization before notice of the cancellation is received by each of the Entities. This authorization expires ten (10) years from the date of execution or upon such earlier date as may be mandated by state law, if applicable. I understand that my prescription may be shipped to my provider on my behalf if requested by my provider.

B. PATIENT MARKETING CONSENT

I further authorize the release of information provided in this enrollment form to Acorda Therapeutics, Inc. (“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. Labcorp Periapproval and Commercialization, Inc. and its affiliates which operate AMPYRA Patient Support Services for Acorda, may receive compensation from Acorda for providing such services and information. 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, to contact me occasionally to obtain feedback (for market research purposes) about Acorda, AMPYRA, or AMPYRA Patient Support Services, 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.

What You Need to Do to Receive Your AMPYRA® Delivery

Ask your doctor to include specific language such as “Dispense As Written” (DAW) on every one of your Ampyra prescriptions including refills to ensure you receive your branded AMPYRA.



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 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.