FORMULARY EXCEPTION POLICY

POLICY: Multiple Sclerosis – Ampyra® (dalfampridine extended-release tablets – Acorda Therapeutics)

DATE CREATED: 7/1/2019

Documentation: Documentation will be required for patients requesting brand Ampyra where noted in the criteria as [documentation required]. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts and/or laboratory data.

CRITERIA

1. Multiple Sclerosis (MS). Approve for 1 year if the patient meets the following criteria (A, B and C):
   A) Ampyra is being used to improve mobility in a patient with MS; AND
   B) Ampyra is being prescribed by, or in consultation with, a neurologist or a physician who specializes in the treatment of MS; AND
   C) The patient meets both of the following criteria (i and ii):
      i. The patient has tried generic dalfampridine [documentation required]; AND
      ii. Brand Ampyra is being requested due to a formulation difference in the inactive ingredient(s) [e.g., differences in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reactions [documentation required].

STORY

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<tr>
<th>Type of Revision</th>
<th>Summary of Changes*</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>New Policy</td>
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<td>07/01/2019</td>
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