

Clinical Policy: Dalfampridine (Ampyra)

Reference Number: CP.PHAR.248

Effective Date: 08.01.16

Last Review Date: 05.25

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Dalfampridine (Ampyra[®]) is a potassium channel blocker.

FDA Approved Indication(s)

Ampyra is indicated to improve walking in patients with multiple sclerosis (MS). This was demonstrated by an increase in walking speed.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that dalfampridine and Ampyra are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Multiple Sclerosis (must meet all):

1. Diagnosis of MS;
2. Prescribed by or in consultation with a neurologist;
3. Age \geq 18 years;
4. Member has sustained walking impairment but is able to walk with or without assistance;
5. If request is for brand Ampyra, member must use **generic dalfampridine**, unless contraindicated or clinically significant changes are experienced;
6. Dose does not exceed 20 mg (2 tablets) per day.

Approval duration:

Medicaid/HIM – 6 months

Commercial – 12 months or duration of request, whichever is less

B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or

- b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Multiple Sclerosis (must meet all):

1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Member is responding positively to therapy;
3. If request is for brand Ampyra, member must use **generic dalfampridine**, unless contraindicated or clinically significant changes are experienced;
4. If request is for a dose increase, new dose does not exceed 20 mg (2 tablets) per day.

Approval duration:

Medicaid/HIM – 12 months

Commercial – 12 months or duration of request, whichever is less

B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CrCl: creatinine clearance
FDA: Food and Drug Administration
MS: multiple sclerosis

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): history of seizure; moderate or severe renal impairment (CrCl \leq 50 mL/min); history of hypersensitivity to Ampyra or 4-aminopyridine
- Boxed warning(s): none reported

Appendix D: General Information

- Use of doses above 10 mg twice daily may increase the risk of seizures. There is no evidence of additional benefit with doses greater than 10 mg twice daily.
- Patients with mild renal impairment (CrCl 51-80 mL/min) may exhibit Ampyra levels that approach those attained at higher doses and that have been associated with a higher risk of seizures. Ampyra should be used with caution in this patient population, and CrCl should be estimated or known prior to initiating Ampyra therapy.
- CrCl can be estimated using the Cockcroft-Gault formula: $CrCl = [(140 - \text{age}) \times (\text{weight in kg}) \times (0.85 \text{ if female})] / (72 \times Cr)$.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
MS	10 mg PO BID (approximately 12 hours apart)	20 mg/day

VI. Product Availability

Tablet: 10 mg

VII. References

1. Ampyra Prescribing Information. Ardsley NY: Acorda Therapeutics, Inc; June 2022. Available at: <http://www.ampyra.com>. Accessed January 23, 2025.
2. Samkoff LM, Goodman AD. Symptomatic management in multiple sclerosis. *Neurol Clin.* 2011; 29: 449-463.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2021 annual review: no significant changes; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	02.08.21	05.21
Revised approval duration for Commercial line of business from length of benefit to 12 months or duration of request, whichever is less	09.27.21	02.22
2Q 2022 annual review: no significant changes; references reviewed and updated.	02.07.22	05.22
Template changes applied to other diagnoses/indications and continued therapy section.	10.10.22	
2Q 2023 annual review: no significant changes; added generic redirection to continued therapy section; references reviewed and updated.	01.30.23	05.23
2Q 2024 annual review: no significant changes; revised policy/criteria section to also include generic dalfampridine; references reviewed and updated.	01.24.24	05.24
2Q 2025 annual review: no significant changes; references reviewed and updated.	02.11.25	05.25

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or

regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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