

Pharmacy Prior Authorization Form

Last Reviewed: Sept. 09

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Amevive[®] (alefacept)

Urgent

Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

Amevive 15 mg powder for injection

Dose: _____ Start date: _____

Place of administration:

Self-administered

Provider's Office

Outpatient Infusion Center

Name of center: _____

Home Infusion

Name of agency: _____

Billing options:

Physician buy and bill (J0215)

Preferred Specialty Vendor

Other: _____

Priority Health Precertification Requirements:

Authorization of Amevive requires:

- Diagnosis of severe plaque psoriasis
 - Involvement of > 10% of body surface area (unless hands, feet, head, neck, or genitalia are involved)
- Documented therapeutic trial of one or more topical agents, phototherapy, and one or more systemic treatments

Continuation of Amevive requires:

- Normal CD4 + T lymphocyte counts
- A minimum of 12 weeks since previous course of treatment was complete

Diagnosis:

Moderate to severe plaque psoriasis– ICD code: _____

Other: _____ – ICD code: _____ Please provide rationale for use:

New request or continuation of therapy:

New (see section 1)

Continuation (see section 2)

Section 1 – New requests:

Plaque affect > 10% of the patient's body surface area:

- Yes
 No

Plaque psoriasis affect the hand, feet, head, neck, or genitalia:

- Yes
 No

Patient had a documented trial and clinical failure of one or more topical agents:

- Yes
 No – Rationale for use: _____

Drug: _____ Trial dates: _____

Drug: _____ Trial dates: _____

Patient had a documented trial and clinical failure with phototherapy (UVA, UVB):

- Yes
 No – Rationale for use: _____

Type of therapy: _____

Patient had a documented trial and clinical failure of one or more systemic treatments (azathioprine, Neoral, methotrexate, cyclosporine, Soriatane):

- Yes
 No

Drug: _____ Trial dates: _____

Drug: _____ Trial dates: _____

Patient have a contraindication to systemic treatments?

- Yes
 No

List the contraindication: _____

Requests for continuation of therapy:

A minimum of 12 weeks passed since the completion of the last course of treatment?

- Yes
 No – Rationale for use: _____

Patient's CD 4 + T lymphocyte count is within the normal range:

- Yes
 No – Rationale for use: _____

***** All fields must be complete and legible for Prior Authorization Review*******Please fax this request to: (877)974-4411 toll free or (616)942-8206****YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**