

# Pharmacy Prior Authorization Form

Last Reviewed: Sept. 11

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<sup>®</sup> (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 &gt; 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: \_\_\_\_\_

**Note:** Priority Health Medicare applies CMS local coverage determination criteria when available for Part B drugs. If no local coverage determination criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

\*\*\* All fields must be complete and legible for Prior Authorization Review\*\*\*

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**YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**