

Fax completed form to: 1-866-868-0858
Questions, please call: 1-866-316-6049



Important Information About Prescription Drug Coverage

To: _____ From: _____

Fax: _____ Pages: _____

Re: Amevive® (alefacept): Prior Authorization Request Form: Please respond.

- Please complete the attached Amevive® (alefacept) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

Please note: By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

Information about this drug

Amevive® (alefacept)

In clinical trials Amevive® resulted in a greater or equal to 75% improvement on the Psoriasis Area and Severity Index (PASI-75) after 12 weeks of therapy in only 21% to 28% of patients compared to 5% to 8% of placebo-treated patients. The low efficacy of Amevive® should be weighed against the potential risks (e.g., infection, malignancy) in the elderly.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

MemberHealth, LLC, PO Box 391197, Solon OH 44139-3911

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Prior Authorization Request Form

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Patient Information

Name _____
Member ID _____
Medicare ID _____
Date of birth _____ Sex: M / F
Address _____
City _____
State _____ ZIP _____
Phone _____
Nursing home resident? YES / NO
Home care patient? YES / NO

Prescriber and Pharmacy Information

Name _____
Specialty _____
DEA _____
NPI _____
Address _____
City _____
State _____ ZIP _____
Phone _____ Fax _____
Pharmacy name _____
NCPDP _____
NPI _____
Phone _____ Fax _____

All items below this line are for Physician Use Only

Information for Requested Drug

Strength: _____ Dosage form: _____ Qty per 30 days: _____ Drug is (circle one): Newly prescribed/Refill
Directions: _____ Diagnosis: _____ ICD-9 Code: _____

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

Amevive® (alefacept) Criteria

- Please indicate Amevive®'s dispensing location:
 the pharmacy
 the physician's supply, incident to a physician's visit.
 other: _____
- Please indicate the patient's diagnosis. Select or indicate the correct ICD-9 code. **This question must be completed.**
 Moderate to severe chronic plaque psoriasis (ICD-9: 696.1) diagnosed for at least one year
 Other (diagnosis and ICD-9 code): _____
- Is the prescribing physician a dermatologist or has a dermatologist been consulted?
 Yes No
- Is at least 10% of the patient's BSA affected by plaque psoriasis?
 Yes No
- Does the patient have any of the following (check any that apply)?
 HIV infection or other clinically important infection
 history of recurrent infections (please specify) _____
 malignancy or history of malignancy
 concomitant immunosuppressant drug therapy or phototherapy
 abnormal CD4 lymphocyte count (less than 250 cells/ μ L)
- Has the patient failed to receive a clinically appropriate therapeutic response OR demonstrated intolerance (e.g., allergy, hypersensitivity, adverse effects(s), development of a contraindication) from at least one systemic DMARD medication (acitretin, methotrexate, cyclosporine) AND at least one topical antipsoriasis medication (e.g., corticosteroid, Dovonex®, Tazorac®, anthralin) over a period of 30 or more days for each drug?
 Yes No
- For refill requests, has 12 weeks elapsed since previous Amevive cycle and has patient demonstrated a positive response to the previous cycle?
 Yes No

Medical justification: (Attach additional page if necessary): _____

Prescriber's signature: _____ Date: _____