HEALTHTRANS

Prior Authorization Request

Date of Request _____

Amevive

Amevive (Alefacept) is used to treat moderate to severe plaque psoriasis.

Patient must be ≥ 18 years of age and have documented chronic (≥ 12 months) plaque psoriasis covering ≥ 10% of the body surface area.

Patient had inadequate response or intolerance to systemic therapy (i.e.-methotrexate, cyclosporine, acitretin) or phototherapy (i.e.- PUVA, UVB).

Patient tested negative for HIV.

Patient has CD4 count >250 cells/ml (normal 500-1500 cells/ml).

[12 weeks]

Reevaluation- if used for 12 weeks and been off for at least 12 weeks.

[12 weeks] Maximum of 24 weeks of therapy.

Member Information

Relationship (Circle)

Subscriber Spouse Dependent

Name _____

Enrollment / Cardholder ID _____

Group / Plan _____

Birth date _____

Gender (Circle)

Male Female

AGE: _____ **Weight (kg):** _____

Address: _____

City State Zip _____

Practitioner Information

Name _____

Agent / Contact Name _____

Specialty _____

Office / Clinic Name _____

Address _____

City State Zip _____

Phone (____) - _____

Fax (____) - _____

ID Number _____

Email _____ @ _____

Chronic (≥ 12 months)? Y N

Negative HIV? Y N

CD4_____cells/ml

Requested Drug / Pharmaceutical

Amevive (Alefacept)

Strength / Dose

Therapy Start Date

Condition / Diagnosis Related - Reason for Request

Duration of Therapy (Expected)

Type of Request (Circle)

One-Time On-Going

Clinical Drug / Lab History Pertinent to Request

Labs: **Baseline / Ongoing**

Formulary Alternative(s) Attempted YES NO (Circle)

Please List:

Contact Pharmacy? Y N

Pharmacy Phone Number

_____

Practitioner Signature

Date Received:
Reviewed By:
Forwarded To:

FAX Form to:
877-800-5633

HT Clinical Services Phone
866-805-1690