



Amevive® (alefacept) Prior Authorization Request Form

Please fax the completed request form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 800-466-9854. For additional information call 314-214-8501 or 800-647-2240.

Patient Name: _____ Today's Date: ____/____/____
Patient Pharmacy ID: _____ Date of Birth: ____/____/____
Requesting Physician: _____ Specialty: _____
Office Contact Person: _____ Phone #: _____ ext: _____
Office Address: _____
Medication/dose Requested: _____ Fax #: _____ ext: _____
Expected Duration of Therapy: _____ ICD-9 _____

INITIAL AUTHORIZATION REQUEST:

- 1. Is the patient > 18 years of age? YES NO
2. Does the patient have a diagnosis of moderate to severe plaque psoriasis? YES NO
3. Is the patient a candidate for systemic therapy or phototherapy? YES NO
4. Does the patient have a CD-4+T lymphocyte count within the normal range? YES NO
5. Will the CD-4+T lymphocyte count be monitored on a weekly basis throughout the course of therapy?. YES NO
6. Does the patient have a clinically important infection? YES NO
7. Does the patient have a history of systemic malignancy? YES NO
8. Is the patient currently receiving other immunosuppressive therapy or phototherapy? YES NO
9. Will the immunosuppressive therapy or phototherapy be discontinued? YES NO

RENEWAL AUTHORIZATION REQUEST:

- 1. Has the patient received treatment with Amevive? YES NO
2. Does the patient have a diagnosis of moderate to severe plaque psoriasis? YES NO
3. Is the patient a candidate for systemic therapy or phototherapy? YES NO
4. Does the patient have a CD-4+T lymphocyte count within the normal range? YES NO
5. Will the CD-4+T lymphocyte count be monitored on a weekly basis throughout the course of therapy? YES NO
6. Did the patient respond to initial therapy, but did not have complete resolution of psoriasis? YES NO
7. Has it been at least 12 weeks since the last Amevive treatment? YES NO
8. Does the patient have a clinically important infection? YES NO
9. Does the patient have a history of systemic malignancy? YES NO
10. Is the patient currently receiving other immunosuppressive therapy or phototherapy? YES NO
11. Will the immunosuppressive therapy or phototherapy be discontinued? YES NO
12. Has the patient received a total of 24 weeks of therapy? YES NO

Physician's Signature: _____ Date: ____/____/____

For Mercy Health Plans use only: [] Approved Length of Approval _____
[] Denied Reason for Denial _____
Reviewer's Signature: _____ Date Reviewed: ____/____/____
Override Entered in [] Caremark [] CCMS for _____ - _____ by _____
Office Notified on _____; at _____ am/pm; by _____ spoke to _____