

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Amevive® (alefacept)

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:

Prior Authorization of Benefits Center at (800) 601- 4829

1. PATIENT INFORMATION

2. PHYSICIAN INFORMATION

Form with fields for Patient Name, ID, DOB, Date of Rx, Phone, Email, Prescribing Physician, Address, Phone, Fax, Specialty, DEA, NPI, and Email Address.

3. MEDICATION

4. STRENGTH

5. DIRECTIONS

6. QUANTITY PER 30 DAYS

Form with checkboxes for Amevive (alefacept), 15mg inj, and a field for Specify.

7. DIAGNOSIS: \_\_\_\_\_

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

Please note: Any areas that are not filled out will be considered not applicable to your patient AND MAY AFFECT THE OUTCOME OF THIS REQUEST

A RESPONSE IS REQUIRED FOR EACH OF THE FOLLOWING:

- List of approval criteria with Yes/No checkboxes: Patient is currently receiving other immunosuppressive therapy or phototherapy, Patient is HIV positive, Patient has CD4+ T lymphocyte count < 250 cells per microliter, Patient has a history of recurrent infection, current chronic infection, clinically important infection, or positive tuberculin skin test (TST) or a CDC-recommended equivalent test, Patient has a history of systemic malignancy within the last 5 years, Patient is receiving concurrent administration of live or live-attenuated vaccines, Patient is 18 years of age or older, Does the patient have chronic moderate to severe plaque psoriasis? If yes, what is the percent of BSA affected?, Patient has had a failure to achieve an adequate clinical response with, or medical contraindication to the use of phototherapy or other systemic therapies (e.g. methotrexate), Disease is controlled with topical therapy.

9. PHYSICIAN SIGNATURE

Prescriber or Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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