

**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**

Patient Name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient Phone #: _____ Patient Email Address: _____	Prescribing Physician: _____ Physician Address: _____ Physician Phone #: _____ Physician Fax #: _____ Physician Specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician Email Address: _____
---	--

**3. MEDICATION**

**4. STRENGTH**

**5. DIRECTIONS**

**6. QUANTITY PER 30 DAYS**

<input type="checkbox"/> Amevive (alefacept)	<input type="checkbox"/> 15mg inj	_____	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:**

- Yes    No   Patient is currently receiving other immunosuppressive therapy or phototherapy
- Yes    No   Patient is HIV positive
- Yes    No   Patient has CD4+ T lymphocyte count < 250 cells per microliter
- Yes    No   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.
- Yes    No   Patient has a history of systemic malignancy within the last 5 years
- Yes    No   Patient is receiving concurrent administration of live or live-attenuated vaccines
- Yes    No   Patient is 18 years of age or older
- Yes    No   Does the patient have chronic moderate to severe plaque psoriasis?  
 If yes, what is the percent of BSA affected?  
 Greater than 5 %    Less than 5 %, involving sensitive areas (head, neck, palms, soles, genitalia)  
 Other: \_\_\_\_\_
- Yes    No   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)
- Yes    No   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.

**IMPORTANT WARNING:** This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is **STRICTLY PROHIBITED**. If you have received this message by error, please notify us immediately at **(800) 338-6180** and destroy the related message or return the document to us at 8407 Fallbrook Avenue AF13, West Hills, CA 91304. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without appropriate patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law.