

MERCY

Health Plans

A Coventry Health Care Plan

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 314-214-8282 or 800-647-2240.

Patient Name: _____

Today's Date: ____/____/____

Patient Pharmacy ID: _____

Date of Birth: ____/____/____

(located on bottom right of insurance card)

Requesting Physician: _____

Specialty: _____

(Please print)

Office Contact Person: _____

Phone #: (____)____-____ ext ____

Office Address: _____

Medication/dose Requested: _____

Fax #: ____ (____)____ - ____

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?
Count: _____ Date: _____ | 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?
Count: _____ Date: _____ | 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 _____