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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 1-844-512-9004
Provider Help Desk 1-800-454-3730

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
Amevive (alefacept)	_____	_____	Specify: _____

7. DIAGNOSIS: _____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

□ Yes □ No	Patient has a diagnosis of plaque psoriasis
□ Yes □ No	Patient has had an inadequate response to phototherapy, systemic retinoids (oral isotretinoin), methotrexate, or cyclosporine (documentation* is required)
□ Yes □ No	Patient has had previous trials and therapy failures with two preferred biological agents (documentation is required) (the preferred biological agents are: Humira, Enbrel, Cosentyx)
□ Yes □ No	Patient has been screened for hepatitis B and C (patients with active hepatitis B will not be considered for coverage)
□ Yes □ No	Patient has been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biological agent
□ Yes □ No	Patient has a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class lll or lV and with an ejection fraction of 50% or less
□ Yes □ No	Patient has been screened for latent TB infection (patients with latent TB will only be considered after one month of TB treatment and patients with active TB will only be considered upon completion of TB treatment)

*Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.

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.