

Amevive (Alefcept) Prior Authorization Request Form

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Retail Pharmacy Program. Express Scripts is the USFHP contractor for DoD.

MAIL ORDER	RETAIL	Amevive is not currently available through the US Family Health Plan Mail Order Pharmacy program.	IF the prescription is to be filled at a retail pharmacy under the USFHP Retail Pharmacy Program, <ul style="list-style-type: none"> To request prior authorization, the provider may call this number: 1-877-880-7007 OR The provider may complete the form, sign, date, and fax to faxed to 1-617-562-5296

Prior authorization criteria and a copy of this form are available at: <http://www.USFamilyHealthPlan.org>. This prior authorization has no expiration date.

Drug for which Prior Authorization is requested: Amevive (alefcept)

Step 1 Please complete patient and physician information (Please Print)

1 Patient Name: _____ Physician Name: _____
 Address: _____ Address: _____
 Sponsor ID: _____ Phone #: _____
 Date of Birth: _____ Secure Fax: _____

Step 2

2 Please complete the clinical assessment

1. Is the patient less than 18 years of age?	<input type="checkbox"/> Yes Coverage not approved	<input type="checkbox"/> No Please proceed to Question 2
2. Is the patient immunocompromised (e.g., due to HIV or other etiology), and/or does the patient have a CD4+ lymphocyte count below normal at start of treatment?	<input type="checkbox"/> Yes Coverage not approved	<input type="checkbox"/> No Please proceed to Question 3
3. Will the patient receive concomitant therapy with another immunosuppressive agent or phototherapy?	<input type="checkbox"/> Yes Coverage not approved	<input type="checkbox"/> No Please proceed to Question 4
4. Is Amevive being prescribed for the treatment of chronic moderate to severe plaque psoriasis in which systemic therapy or phototherapy is indicated?	<input type="checkbox"/> Yes Please sign and Date	<input type="checkbox"/> No Coverage Not Approved

Quantity Limits: limited to a 4 week supply in retail.

Step 3 I certify the above is correct and accurate to the best of my knowledge. Please sign and date

3

_____ Date _____
 Prescriber Signature