

Health New England Medication Request Form (MRF)

Amevive™ (alefacept)

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

- Prior Authorization Only
- Prior Authorization and Drug Delivery Request

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Amevive™. Please complete this form and fax to ICORE Healthcare at (866)-364-2673. If you have any questions regarding this process, please contact ICORE Healthcare at (800) 775-5138.

Medication Request Information (please complete each section of this form prior to transmittal):

J-Code = J0215. 1 unit = 0.5 mg given IM

Patient Information (all required)	Physician Information (all required)
Patient Name:	Physician Name:
Patient Cell Phone # () -	Specialty:
Patient HNE ID#:	NPI #:
Patient Date of Birth:	HNE Provider #:
Allergies:	DEA # :
Diagnosis:	Area Code and Telephone #: () -
	Area Code and Fax #: () -

Drug Information

Requested Drug / strength: Amevive		
Dose, directions and length of treatment (please be specific):	Quantity (per month):	Refills:

Physician signature:	Date:
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Indication:

- For moderate to severe Plaque Psoriasis

Severity

- Body Surface Area Involvement (percent): _____%
- PASI (Psoriasis Area and Severity Index) Score: _____(range 0 to 72)

Documentation of Medical Necessity (check all that apply):

- Amevive is recommended by a Dermatologist within the previous 6 months.
- Active infections (including, but not limited to histoplasmosis, cytomegalovirus, tuberculosis, HIV, and local infections) have been excluded.
- Patient is not concurrently receiving other immunosuppressive agents (including but not limited to cyclosporine, methotrexate, etanercept, alefacept, infliximab) or phototherapy.
- CD4+ T-lymphocyte count _____
- Date of last dose of Amevive _____
- Other pertinent history _____.

Check other drugs/treatments tried or contraindicated (check all that apply):

- | | | |
|---------------------------------------|---------------------------------------|------------------------------------|
| <input type="checkbox"/> PUVA | <input type="checkbox"/> UVB | <input type="checkbox"/> Acitretin |
| <input type="checkbox"/> Methotrexate | <input type="checkbox"/> Cyclosporine | |