

Date/Time of Request: Date: _____ Time: _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of Amevive® (alefacept). Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. – Member Information:

Patient Name:	Plan Name/Plan ID:	
Patient ID:	Patient Date of Birth:	Patient Contact Phone#:

B. – Physician Information

Physician Name:		Physician Address:	
Physician DEA #:		Physician Phone #:	Physician Fax Number:
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC#:

C. – Pharmacy Information

Pharmacy Name:	NABP #:	Pharmacy Phone Number:	Pharmacy Fax Number:
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D. – Clinical Information: Please fill out the following clinical information: (circle all that apply)

- Does the patient have a diagnosis of moderate to severe chronic plaque psoriasis? (>10% BSA) YES NO
- Please list treatment failure with topical steroids?
 Medication: _____ Duration of therapy: _____
 Medication: _____ Duration of Therapy: _____
- Please list treatment failure with at least one systemic agent?
 Medication: _____ Duration of therapy: _____
- Has the patient failed treatment of phototherapy? If yes please provide dates: _____ YES NO
- Please provide patient's WBC count.
 Most recent lab result: DATE: _____ WBC: _____

Dosing Recommendations:

7.5 mg IV bolus once weekly or 15 mg IM once weekly, for a course of 12 weekly injections. Retreatment with an additional 12-week course may be initiated provided that CD4+ T-lymphocyte counts are within the normal range, and a minimum of a 12-week interval has passed since the previous course of treatment.

Authorized Medical Signature:			
Telephone:		Date:	

When Completed Return To: ProCare PBM Clinical Division 3090 Premiere Parkway Ste 100 Duluth, GA 33097
1-866-965-Drug (3784) / Fax # 866-999-7736

Receipt Date/Time of Completed Request: _____		FOR INTERNAL USE ONLY		Ticket Number: _____	
<input type="checkbox"/> Approved	<input type="checkbox"/> Denied	(Date/Time)	Member Contacted:	_____	
Reviewed by: _____	Effective Date: _____	MD Contacted:	_____		
Review Date: _____	Termination Date: _____	Pharmacy Contacted:	_____		
Review Time: _____					