

OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION REQUEST FORM*

Directions: *The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff and faxed to 757-552-7429 or 1-877-800-2839. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct.*

Drug Name: AMEVIVE[®] (alefacept) Code J-0215

- AMEVIVE[®] is indicated for the treatment of adult patients with moderate to severe chronic plaque psoriasis who are candidates for systemic or phototherapy

Amevive[®] is contraindicated in:

- Ages < 18 years
- Geriatric population
- Pregnancy
- CD4+ T-lymphocyte counts of < 250 cells/uL
- History of malignancies
- Any clinically important infection
- Immunosuppressants
- Phototherapy

Diagnosis

(Check one):

- Moderate to severe chronic plaque psoriasis

Indicate Psoriasis Affected Area

Please complete below:

(ALL lines must be checked to qualify)

- Prescriber is a dermatologist
- Psoriasis involves: palms, soles, face, genitalia, or greater than 10% of total body surface area
- Symptom duration of 12 months or more
- Documented failure of phototherapy or alternative systemic therapy
- Trial and failure of Enbrel[™] (etanercept)

* If the clinical indications are met, one 12-week course (1 dose weekly) will be approved. Repeat therapy will be covered if there is a documented meaningful clinical response.

Patient _____

Member Number _____

Signed _____ Date _____

Physician Name _____ Phone Number _____

Fax Number _____

Pharmacy Name _____ Pharmacy Tel # _____

