

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

AMEVIVE (alefacept)

Patient name: _____ Medicaid or SS# _____

Physician Name: _____ Contact person: _____

Phone#: _____ Ext. and opt. _____ Fax# _____

Pharmacy _____ Pharmacy Phone#: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY (801) 536-0477**

CRITERIA:

- ▶ Severe Chronic Plaque Psoriasis
- ▶ Candidate for systemic or photo-therapy
- ▶ Lack of other concomitant immunosuppressive agents
- ▶ Step therapy which includes trial of Methotrexate, Acitretin (Soriatane) or Methoxsalen, rapid, Oxsoresalen-Ultra and Cyclosporin
- ▶ Minimum body surface area involvement >10%

INFORMATION:

To be given in clinic setting only. Patients with HMO's (except IHC) will have to make arrangements with their HMO for coverage. Provider will bill with J code 3490 and PA number.

AUTHORIZATION:

Initial authorization is for 12 weekly injections

RE-AUTHORIZATION:

Additional 12 week course may be initiated provided CD4+T lymphocyte counts are within normal range and a minimum of 12 weeks have passed since the previous course of treatment. Maximum annual coverage is 24 weeks.

