

APPLIES TO COMMERCIAL AND MEDICAID  
**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)
<b>Patient Name:</b>	<b>Physician Name:</b>
<b>Patient Cell Phone # ( ) -</b>	<b>Specialty:</b>
<b>Patient HNE ID#:</b>	<b>NPI #:</b>
<b>Patient Date of Birth:</b>	<b>HNE Provider #:</b>
<b>Allergies:</b>	<b>DEA # :</b>
<b>Diagnosis:</b>	<b>Area Code and Telephone #: ( ) -</b>
	<b>Area Code and Fax #: ( ) -</b>

**Drug Information**

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

<b>Physician signature:</b>	<b>Date:</b>
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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, certolizumab) 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 |                                    |