



Send completed form to:
 Peach State Health Plan Pharmacy Department
 Fax: 1-866-374-1579

Amevive

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at 1-800-514-0083 option # 2.

Patient Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Physician Office Address: _____

1. Which drug is being prescribed?
 Amevive, Dose: _____ Frequency: _____
 Other _____
2. What is the diagnosis?
 Psoriasis
 Other _____
3. What is the ICD9 code? _____
4. How old is the patient? _____ years
5. Does the patient have negative tuberculosis (TB) test? *If Yes, Skip to # 8 Yes No
6. Has active TB been ruled out via negative chest x-ray? Yes No
7. Was the chest x-ray taken within 12 months? Yes No
8. Has the patient had a negative screening for human immunodeficiency virus (HIV)? Yes No
9. Does the patient have history of or high risk for systemic malignancy? Yes No
10. Does the patient have any signs of new or active infection? Yes No
11. Will the patient be monitored for CD4+ count every *other week* for the entire 12 week course of Amevive therapy? Yes No
12. Is the *prescribing* physician a dermatologist? Yes No
13. Was the diagnosis made by a dermatologist? Yes No
14. Is psoriasis moderately to severely active? Yes No

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Patient Name: _____ Patients Date of Birth: _____
Patients ID : _____

15. What is the **BASLINE** CD4+ count?
 Greater than 500 cells/uL **Less than or equal to** 500 cells/uL
16. What is the percentage of body surface area (BSA) affected? _____ %BSA
17. Does the patient's psoriasis involve palms, soles, face and neck, body folds, or genitalia?
 Yes No
18. Has the patient received a prior biologic for psoriasis? (i.e. Enbrel, Humira, Remicade, or Stelara)
**If Yes, Skip to # 23* Yes No
19. Has the patient had trials of **ALL three of the following therapies for 3 consecutive months**?
 Yes No **If No, Skip to # 22*
- Topical treatment (calcipotriene, medium to high potency corticosteroids, tazarotene, coal tar preparations, anthralin)
 - Phototherapy
 - One systemic therapy (methotrexate, thioguanine, cyclosporine, acitretin)
20. Has the patient had an inadequate response to the above therapies? (*see question 19*) Yes No
21. Was the patient adherent to each of the prescribed therapies? (*see question 19*) Yes No
If Yes, Document last trail of conventional therapy: _____
22. Is the patient contraindicated or intolerant to such therapies? (*see question 19*) Yes No
Unless contraindicated, **document last trail of conventional therapy:** _____
23. Has the patient had an inadequate response to prescribed biologic therapy? (i.e. Enbrel, Humira, Remicade, or Stelara) Yes No **If No, skip to # 25*
24. Was the patient adherent to prescribed biologic therapy? (i.e. Enbrel, Humira, Remicade, or Stelara)
 Yes No If Yes, Document last trail of biologic therapy: _____
25. Was the patient intolerant to previous biologic therapy? (i.e. Enbrel, Humira, Remicade, or Stelara)
 Yes No If Yes, Document last trail of biologic therapy: _____
26. Is the patient currently receiving Amevive therapy? Yes No **If No, no further questions*
Only answer the below questions if patient is currently receiving Amevive therapy.
27. Has the patient received a total of 2 courses of Amevive therapy? Yes No
28. How many TOTAL courses of Amevive therapy has patient received? _____
29. Has the patient demonstrated positive therapeutic response from previous course? Yes No
30. Has the patient developed any type of malignancy? Yes No
31. What is the **CURRENT** CD4+ count?
 Greater than 500 cells/uL **Less than or equal to** 500 cells/uL
32. Will Amevive dose be withheld if CD4+ counts fall below 250 cells/uL? Yes No

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Patient Name: _____ Patients Date of Birth: _____
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33. Will Amevive be discontinued if CD4+ counts remain below 250 cells/uL for one month?
 Yes No
34. Has it been at least 12 weeks since last Amevive injection? Yes No
35. How many weeks has it been since last Amevive injection? _____ weeks

****NOTE: We can NOT make a decision without a copy of the documentation - Thank You****

Information given on this form is accurate as of this date:

X _____
Prescriber or Authorized Signature Date (mm/dd/yy)

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