CVS CAREMARK

Fax Referral To: 800-323-2445
Phone: 866-278-6634

Amevive® (alefacept)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Contact Phone: _____

INSURANCE INFORMATION *(If available, please copy and attach the front and back of insurance and prescription drug card)*

Primary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI**
Secondary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 Code): ☐ 696.1 Psoriasis ☐ Other: _____ • Date of Diagnosis: _____

Approval Criteria: CHECK ALL BOXES THAT APPLY

Please note: Any areas that are not filled out will be considered not applicable to your patient AND MAY AFFECT THE OUTCOME OF THIS REQUEST

- Does the patient have moderate to severe plaque psoriasis? ☐ Yes ☐ No
  - What is the percent of BSA affected?
    - ☐ Greater than 10% of body surface area with plaque psoriasis
    - ☐ Less than or equal to 10% body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of Feet, head/neck, or genitailia)
    - ☐ Other: _____
- Is the patient a candidate for systemic and/or phototherapy? ☐ Yes ☐ No
- Does the patient have a failure of or contraindication to prior systemic and/or phototherapy? ☐ Yes ☐ No

Are any of the following present:

- Less than 12 weeks have elapsed since previous course of treatment ☐ Yes ☐ No
- Patient has CD4+ T lymphocyte count <250 cells per microliter ☐ Yes ☐ No
- Patient has a history of recurrent infection, or current chronic infection, or clinically important infection, or positive tuberculin skin test ☐ Yes ☐ No
- Patient has a history of systemic malignancy within the last 5 years ☐ Yes ☐ No
- Patient is currently receiving systemic psoriasis, or immunosuppressive therapy ☐ Yes ☐ No
  - Comments: _____
- Patient is pregnant or nursing ☐ Yes ☐ No
- Patient is less than 18 years of age ☐ Yes ☐ No

Requests for off-label use of Amevive will be reviewed and approved when sufficiently supported by evidence from major compendia, published peer-reviewed medical literature, nationally accepted practice guidelines, or expert consensus statements. The major compendia that are recognized include AHFS® Drug Information, Thomson Micromedex®, National Comprehensive Cancer Network Drugs and Biologics Compendium™, and Clinical Pharmacology.

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Amevive® (alefacept)	15mg injection			

_____ _____
PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)