

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM  
**AMEVIVE** (alefacept)

Patient name: \_\_\_\_\_ Medicaid or SS# \_\_\_\_\_

Physician Name: \_\_\_\_\_ Contact person: \_\_\_\_\_

Phone#: \_\_\_\_\_ Ext. and opt. \_\_\_\_\_ Fax# \_\_\_\_\_

Physician's NPI# \_\_\_\_\_

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

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

**CRITERIA:**

- ▶ Age requirement: 18 years old and older
- ▶ Moderate to Severe Chronic Plaque Psoriasis
- ▶ History of incomplete response or intolerance to at least one appropriate systemic agent or photo therapy
- ▶ Negative TB skin test or history of treatment for latent TB infection
- ▶ Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition
- ▶ Dermatology consultation within the last 60 days.

**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.