

UPMC HEALTH PLAN

AMEVIVE

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-979-UPMC (8762)

FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone:		Provider Fax:	Provider NPI #:

Patient Name:		Patient UPMC Health Plan ID Number:		Patient DOB:
Drug Requested:	Strength:	Frequency:	Qty Dispensed:	Patient Age:

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

<input type="checkbox"/> New medication	If ongoing, provide date started:	If medication is ongoing, Did the member show improvement while on therapy?	<input type="checkbox"/> Yes
<input type="checkbox"/> Ongoing medication			<input type="checkbox"/> No

Diagnosis:	Date of diagnosis:
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Please indicate place of administration / infusion:	<input type="checkbox"/> Physician's Office	Please indicate how medication will be billed:
	<input type="checkbox"/> Hospital/Facility	
Please provide facility/provider name and address:		<input type="checkbox"/> Billed directly by the provider via JCODE Provide JCODE: _____
		<input type="checkbox"/> Billed by a pharmacy and delivered to the provider
		<input type="checkbox"/> Billed by a pharmacy and delivered to the patient

Please complete the following questions

Please indicate Plaque Psoriasis disease severity: Mild Moderate Severe

Is there evidence of Infection? Yes No

Is the member currently using another TNF-blocking agent, biologic agent, phototherapy, or immunosuppressant in combination with Amevive? Yes No
If yes, please indicate drug name:

Please indicate body surface area (BSA) involvement: Less than 10% Greater than or equal to 10%

Does the member have psoriasis on the palms, soles, head, neck, or genitalia? Yes No

Has the member tried and failed topical treatments? Yes No
If yes, indicate drug name(s):

Has the member tried and failed phototherapy or photochemotherapy? Yes No

Please indicate if the member tried and failed any of the following for at least 3 months?
 Methotrexate Cyclosporine (Neoral, Sandimmune) Acitretin (Soriatane)

Please indicate dates of therapy and dose:

Please indicate reason for discontinuation:

Please indicate if the member tried and failed any of the following TNF blocking agents for at least 3 months?
 Enbrel Remicade Cimzia Humira Simponi

Please indicate dates of therapy and dose:

Please indicate reason for discontinuation:

Please indicate CD4 lymphocyte count: _____ Date of test: _____

Does the member have Human Immunodeficiency Virus (HIV)? Yes No

Please provide any additional information which should be considered in the space below:

