



Date _____

Client _____

PRIOR AUTHORIZATION QUESTIONNAIRE - AMEVIVE®

M.D. Last Name: _____ M.D. First Name: _____

Physician Phone: _____ Physician Fax: _____

Patient _____ ID# _____ DOB _____

****FAILURE TO COMPLETE THE FORM MAY RESULT IN AN AUTOMATIC DENIAL****

PLEASE NOTE: FOR ALL REQUESTS, PLEASE ATTACH THE MOST RECENT COPY OF THE PATIENT'S PROGRESS NOTES

- | | | |
|---|-----|----|
| 1. Does the patient have a diagnosis of moderate to severe plaque psoriasis? | Yes | No |
| 2. Is the patient a candidate for systemic therapy or phototherapy? | Yes | No |
| 3. Does the patient have a CD-4+T lymphocyte count within the normal range?
(CD-4+ T-lymphocyte normal range 359-1725 cells/ μ L) | Yes | No |
| 4. Will the CD-4+T lymphocyte count be monitored on a weekly basis through out the course of therapy? | Yes | No |
| 5. Does the patient have HIV? | Yes | No |
| 6. Does the patient have a different clinically important infection? | Yes | No |
| 7. Does the patient have a history of systemic malignancy? | Yes | No |
| 8. Is the patient currently receiving other immunosuppressive therapy or phototherapy?
[Tech Only: If the answer to this question is no, then no further question are required.] | Yes | No |
| 9. Will the immunosuppressive therapy or phototherapy be discontinued? | Yes | No |
| 10. Has the patient received treatment with Amevive? | Yes | No |
| 11. Did the patient respond to initial therapy, but did not have complete resolution of psoriasis? | Yes | No |
| 12. Has it been at least 12 weeks since the last Amevive treatment? | Yes | No |
| 13. Has the patient received a total of 24 weeks of therapy? | Yes | No |

Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

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QUESTIONS PLEASE CALL:
877-526-9906