

Drug Coverage Review Request

Amevive[®] & Raptiva[®]



SUPPLY ALL PRESCRIBER AND PATIENT INFORMATION

PRESCRIBER

MD First Name _____
MD Last Name _____
Address _____
City _____
State _____
Zip Code _____
Phone _____
Fax _____
DEA number (optional) _____

PATIENT

Cardholder ID # _____
Patient Last Name _____
Patient First Name _____
Date of Birth _____
Address _____
City _____
State _____
Zip Code _____
Phone _____

Your patient's benefit plan requires that we review certain requests for coverage with the prescribing physician. This includes requests for benefit coverage beyond plan specifications. Please complete the following questions and then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the benefit plan's rules.

SECTION A

Please answer the following questions

- Yes No **If the prescribed drug is Raptiva**, is the patient new to therapy with this medication or restarting therapy following a period off of this medication?
- For which condition is this drug being prescribed?
 Moderate or severe plaque psoriasis
 Other
- Yes No Is the patient CURRENTLY RECEIVING the prescribed drug?
- Yes No If **Yes** to **previous** question, has this drug therapy provided SIGNIFICANT IMPROVEMENT in the patient's plaque psoriasis?
 Not applicable (patient has not been on the medication long enough to determine this)
- Yes No Is this drug being prescribed or recommended by a dermatologist?
- Yes No Has the patient already been treated with phototherapy (such as PUVA or broadband or narrowband UVB)?
- Yes No If **No** to **previous** question, is the patient a CANDIDATE for receiving phototherapy?
 Phototherapy not available to the patient
- Yes No Has the patient ALREADY RECEIVED OTHER SYSTEMIC DRUG THERAPIES such as methotrexate, cyclosporine, or acitretin (*Soriatane*)?
- Yes No If **No** to **previous** question, is the patient a CANDIDATE FOR OTHER SYSTEMIC THERAPIES such as methotrexate, cyclosporine, or acitretin (*Soriatane*)?
- Yes No Will the patient be receiving MORE THAN ONE biologic agent at the same time?

Answer questions 11 and 12 if the prescribed medication is **Amevive**

- Yes No Has the patient received TWO OR MORE 3-month treatment cycles with this drug?
- Yes No Have at least 3 months elapsed since the patient's last course of this drug?
 Not applicable (this is the patient's first course of therapy)

SECTION B

Physician Signature

PHYSICIAN SIGNATURE _____

DATE _____

FAX COMPLETED FORM TO: 1 800 837-0959

PLEASE DO NOT FAX WITH A COVER SHEET



Confidentiality Notice: This communication and any attachments are intended solely for the use of the addressee named above and contain confidential and legally privileged information. If you are not the intended recipient, any dissemination, distribution or copying is strictly prohibited. If you receive this communication in error, please notify Medco by fax or phone immediately. Medco facsimile machines are secure and in compliance with HIPAA privacy standards. **THE PROVISION OF THE INFORMATION REQUESTED IN THIS FORM IS FOR YOUR PATIENT'S BENEFIT. MEDCO DOES NOT COMPENSATE FOR COMPLETING THIS FORM.**