

Complete Patient and Physician information (PLEASE PRINT)

STEP 1	Member Name:	Physician Name:
	Address:	Address:
	Member ID:	Phone #:
	Member DOB:	Fax #:

If Applicable: Pharmacy Name: _____
 Pharmacy Phone: _____

Complete the Clinical Assessment:

STEP 2	Diagnosis	<input type="checkbox"/> Moderate to severe chronic plaque psoriasis	<input type="checkbox"/> Other (please state):
	Clinical Consideration	<input type="checkbox"/> Patient must have tried photo therapy or be an inappropriate candidate for photo therapy. <input type="checkbox"/> Patient must have documented intolerance to oral therapy, or be an inappropriate candidate for oral therapy.	
	Physician Specialty	<input type="checkbox"/> Rheumatologist	<input type="checkbox"/> Dermatologist <input type="checkbox"/> Other (please state):
	Supporting Documentation	Diagnosis: ICD-9 Code #/ Description (required): Please attach a copy of the prescription or provide ALL of the information below: <input type="checkbox"/> Amevive® (alefacept) Strength _____ Sig _____ Qty _____ Refills _____ Please attach all relevant medical records and test results. Incomplete forms will not be processed.	

I certify that the above is correct and accurate to the best of my knowledge (please sign and date).

STEP 3	Prescriber Signature _____	Date _____
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**Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:
 970-248-5034**

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

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