AMEVIVE® (alefacept)

Prescription, Patient Authorization to Disclose Health Information & AMEVIVE® Start Assistance Program Enrollment Form

Phone: 866-AMEVIVE (263-8483) • Fax: 866-420-8888

Prescribing Physician Information	***Patient Information***
Physician Name (First/Last):	Patient Name (First/M.I./Last):
Site Name:	Street Address:
Street Address:	City: State: Zip Code:
City: State: Zip Code:	Work phone: Home Phone:
Telephone: Fax:	Patient may be contacted at: [ ] W [ ] H ______ Best time Female [ ] Male [ ]
Office Contact: Tax ID #:	Date of Birth: Soc. Sec. #:
State License #: DEA #:	

Ship To (if different than Prescribing Physician address)	***Patient Insurance Information***
	Please attach copies of both sides of patient's insurance cards
Ship to Site Name:	***Prescription***
Street Address:	**AMEVIVE® (alefacept)**
City: State: Zip Code:	**Inject 15mg IM weekly**
Telephone: Fax:	**Dispense: 1 Administration Pack (4-week supply)**
Anticipated date of first/next injection:	**Refills: 2**
	Special Instructions:
AMEVIVE® will be shipped upon receipt of a validated prescription and receipt of any co-pay from the patient	Special Precautions (e.g., allergies):

Statement of Medical Necessity

Primary Diagnosis: ICD-9 696.1 I will be administering the patient's treatment accordingly. I authorize therapy for 12 doses.

Previous Treatments: PUVA [ ] UVB [ ] Methotrexate [ ] Cyclosporine [ ] Oral Retinoids [ ] Other [ ]

Pertinent Medical History: ______

Physician Signature

I authorize Astellas Pharma US, Inc. ("Astellas") and its representatives (1) to use the information in Part 1 and Part 2 (if applicable) on this form to enroll the above-named patient in Astellas' AMEVIVE® Start Assistance Program,(2) to forward the above statement of medical necessity and furnish any information on this form to the insurer of the above-named patient, (3) forward the above prescription by fax or by another mode of delivery to an Astellas network specialty pharmacy provider, and (4) to coordinate delivery of AMEVIVE® on behalf of the above-named patient.

Physician Signature **X** ______ Date: ______

Patient Authorization to Disclose Health Information and Enrollment in the AMEVIVE® Start Assistance Program

Unless the box below is checked, I request the Astellas Pharma US, Inc. ("Astellas") forward this prescription by fax or by another mode of delivery to an Astellas network specialty pharmacy provider for purposes of fulfilling and coordinating delivery of AMEVIVE® to my physician. If a network specialty provider is not available, I authorize Astellas to investigate other insurance coverage options available to me to access AMEVIVE®. By signing this Authorization below, I authorize my physician and my health insurance company to disclose to Astellas my health information relating to my medical condition, treatment and insurance coverage that is needed to verify my insurance coverage for AMEVIVE® and to coordinate delivery of AMEVIVE® to my physician. Once my health information has been disclosed to Astellas, I understand that federal privacy laws may no longer protect the information. Astellas agrees to protect my health information by using and disclosing it only for the purposes authorized in this form. This limitation will continue even after the expiration or revocation of my authorization. I also would like to enroll in the Astellas AMEVIVE® Start Assistance Program ("ASAP") for patients taking AMEVIVE®. I understand that I may refuse to sign this Authorization and choose not to participate in ASAP, that my physician and my health insurance plan will not be a condition for my treatment, payment for treatment, insurance enrollment, or eligibility for insurance benefits on my agreement to sign the Authorization and that I am entitled to a copy of this Authorization. I may cancel this Authorization at any time by mailing a letter to: AMEVIVE® Start Assistance Program, 10350 Ormsby Park Pl. Ste. 500, Louisville, KY 40223. Canceling this Authorization will end my enrollment in ASAP and further disclosure of my health information to Astellas after the date Astellas receives my letter, but will not affect my enrollment in ASAP or Astellas' use of health information disclosed before recipient of my letter. Canceling this Authorization will not affect my ability to receive treatment with AMEVIVE®. This Authorization expires five years from the date it is signed by me.

[ ] By checking this box, I request that Astellas, the owner of AMEVIVE®, and its representatives investigate all insurance coverage options available to me to access AMEVIVE® before forwarding this prescription to a network specialty pharmacy provider. While every effort is made to investigate insurance coverage and to provide helpful information, Astellas makes no representations about the eligibility or guarantee of coverage or reimbursement for any particular claim.

Patient Signature **X** ______ Date: ______

Parent or Guardian Signature **X** ______ Date: ______
(for patients under 18 yrs.)

AMEVIVE® is not indicated for pediatric patients. Astellas makes no representation about the eligibility or guarantee of coverage or reimbursement

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Patient Information

Patient First Name ________ Last Name ________ Initial ________ Social Security # ________

State Of Medical Necessity

Current State of disease. Moderate [ ] Moderate – Severe [ ] Severe [ ] %BSA ________

Current treatment and response ________

Year of Diagnosis Date ________ Patient Age at Diagnosis ________

Previous Treatment.

Phototherapy

- [ ] UVB From ________ To ________ Response ________
- [ ] PUVA From ________ To ________ Response ________

Systemics

- [ ] Methotrexate From ________ To ________ Response ________
  Total Dose ________
- [ ] Cyclosporine From ________ To ________ Response ________
- [ ] Retinoids
  Etretinate or Acitretin From ________ To ________ Response ________
- [ ] Azathioprine From ________ To ________ Response ________
- [ ] Sulfasalazine From ________ To ________ Response ________
- [ ] Hydroxyurea From ________ To ________ Response ________
- [ ] Etanercept From ________ To ________ Response ________
- [ ] Mycophenolate mofetil From ________ To ________ Response ________
- [ ] Infliximab From ________ To ________ Response ________
- [ ] Other From ________ To ________ Response ________
  From ________ To ________ Response ________

Pertinent Medical History. ________

Part II