

**AMEVIVE®**  
**PREAUTHORIZATION REQUEST**  
**PHYSICIAN FAX FORM**



**BlueCross BlueShield**  
**of Illinois**

**ONLY the prescribing physician may complete and fax this form.**

**Incomplete forms will be returned for additional information.** The following documentation is required for preauthorization consideration. For formulary information and to download additional forms, please visit [www.bcbsil.com](http://www.bcbsil.com)

**Patient first name** \_\_\_\_\_ **Patient last name** \_\_\_\_\_

**Blue Cross ID number** \_\_\_\_\_ **Date of birth (MM/DD/YYYY)** \_\_\_\_\_

**Patient address** \_\_\_\_\_

Requesting physician \_\_\_\_\_

Physician specialty \_\_\_\_\_ Physician UPIN# \_\_\_\_\_ Physician NPI# \_\_\_\_\_

Physician signature \_\_\_\_\_ Date \_\_\_\_\_

Physician (clinic name) and address \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_

Patient diagnosis \_\_\_\_\_

1. Is the patient currently treated with Amevive?  Yes  No

If yes, duration of treatment \_\_\_\_\_

2. If the patient is currently prescribed Amevive, has the treatment been beneficial in achieving remission of the disease or decreasing symptom severity?  Yes  No

3. Has the patient been treated previously with Enbrel or Raptiva and therapy is now being switched to Amevive?  Yes  No

If yes, will Enbrel or Raptiva be discontinued prior to the start of Amevive?  Yes  No

4. Please list current and previous topical or systemic antipsoriatic agents used  
\_\_\_\_\_  
\_\_\_\_\_

5. Is the patient allergic to, intolerant of, or have contraindications to the use of topical or systemic antipsoriatic agents?  Yes  No

**PLEASE FAX OR MAIL THIS FORM TO:**  
Blue Cross and Blue Shield of Illinois  
c/o Prime Therapeutics LLC, Clinical Review Department  
1020 Discovery Road, No. 100  
Eagan, Minnesota 55121

**TOLL FREE:**  
**Fax:** 877.480.8130 **Phone:** 800.285.9426

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