AMEVIVE® (alefacept) Prescription, Patient Authorization to Disclose Health Information, and AMEVIVE® Start Assistance Program Enrollment Form

Telephone: 866-AMEVIVE (866-263-8483) Fax: 866-420-8888

Prescribing Physician Information

Physician Name (First, Last) _____

Site Name _____

Street Address _____

City _____ State _____ ZIP _____

Telephone _____ Fax _____

Office Contact _____ Tax ID # _____

State License _____ DEA # _____

National Provider Identification # _____

Patient Information

Patient Name (First, MI, Last) _____

Street Address _____

City _____ State _____ ZIP _____

Work Phone _____ Home Phone _____

Patient may be contacted W_____ H _____ Time _____

DOB _____ SS # _____ Female __ Male __

Prescribing Physician Information

Insurance Name _____ Insurance State _____ Insurance Phone _____ Provider # _____

Patient ID # _____ Group # _____ Policy Holder _____ Employer _____

Submit a copy of patient's insurance card (front and back) with this form.

Statement of Medical Necessity

Primary Diagnosis: ICD-9 696.1

Date of Diagnosis _____

BSA _____%

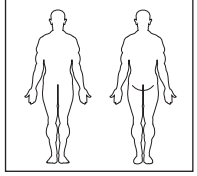
Severity

___ Moderate ___ Moderate-Severe ___ Severe

I authorize therapy for 12 weeks.

_____ MD Initials

Circle affected areas.



Prior Treatments	Date	Response
____Topicals	____thru____	___Poor___Fair___Good___Excellent
____PUVA____UVB	____thru____	___Poor___Fair___Good___Excellent
____Methotrexate	____thru____	___Poor___Fair___Good___Excellent
____Cyclosporine	____thru____	___Poor___Fair___Good___Excellent
____Oral Retinoids	____thru____	___Poor___Fair___Good___Excellent
____AMEVIVE®	____thru____	___Poor___Fair___Good___Excellent
____Other_____	____thru____	___Poor___Fair___Good___Excellent

Pertinent Medical History: _____

_____

Physician Signature

I authorize Astellas Pharma US, Inc. ("Astellas") and its representatives (1) to enroll the above-named patient in the 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) to 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 _____ **Date** _____

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

Unless the box below is checked, I request that 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 receipt of my letter. Canceling this Authorization will not affect my ability to receive treatment with AMEVIVE®. This Authorization expires two 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 _____ **Date** _____

Parent or Guardian Signature _____ **Date** _____
(for patients under 18 years)

AMEVIVE® is not indicated for pediatric patients. Third-party payment for medical products and services is affected by numerous factors. Astellas Pharma US, Inc. and PsoriasisSupport℠ do not guarantee that you will be successful in obtaining insurance payments.