



Prior Authorization Approval Criteria

Amevive (alefacept)

Generic name:	Alefacept
Brand name:	Amevive
Medication class:	Antipsoriatic, systemic
FDA-approved uses:	For the treatment of adult patients with moderate to severe chronic plaque psoriasis who are candidates for systemic therapy or phototherapy
Usual dose range:	7.5 mg once weekly as an IV bolus
Duration of therapy:	12 weeks, may be able to give more than one course of therapy

Criteria for use (*bullet points below are all inclusive unless otherwise noted*):

- Severe chronic psoriasis, covering more than 10% of their body
- Failed/intolerant to at least one of the following:
 - topical steroids
 - topical vitamin D
 - coal tar.
- Failed/intolerant to at least one of the following:
 - Methotrexate
 - Cyclosporine
 - oral retinoids.
- Failed/intolerant to at least one of the following:
 - phototherapy (PUVA)
 - light therapy.
- Over the age of 18 years
- Must be able to obtain weekly lymphocyte counts

Criteria for Continuation of Therapy:

- Improvement in PASI score by 50% from baseline assessed 2 weeks after 12th dose, or a decrease by 50% in psoriatic areas
- Not treated with alefacept within the last 12 weeks.
- CD4-T lymphocytes counts are above 250 cells/uL

Caution

- Secondary malignancies have developed; most malignancies are dermal, with lymphomas being the second most common.
- Women who are pregnant or become pregnant while on alefacept must register with the Biogen Pregnancy Registry by calling 866-263-8483. The effect of alefacept on the fetus is not known.
- Caution should be used when treating patients over 65 years of age, due to the increased risk of infections and malignancies.

Not approved if:

- Infection
- History of systemic malignancy
- History of skin malignancy
- Unable to obtain weekly blood test (CD4 count/ T-cell count)
- Has had alefacept within 12 weeks
- CD4-T lymphocytes count below 250 cells/uL
- Prior treatment with alefacept has not lowered baseline CD4 count
- Can not have weekly lymphocyte blood counts
- Patient is immunosuppressed

FCHP Pharmacy and Therapeutics Committee approval: _____

Date: _____

Adopted: 11/12/2004