

MOZOBIL (plerixafor) PRIOR AUTHORIZATION FORM

- Please submit **all** requested documentation with this form. Incomplete documentation may delay the processing of this request.
- Prior authorization guidelines may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Mozobil** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).
- Mozobil subject to quantity limits. If the requested quantity exceeds the limit, please submit supporting chart documentation (refer to Quantity Limits list at: <http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm>).

PRIOR AUTHORIZATION INFORMATION			PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request:	Prescriber name:	
<input type="checkbox"/> Renewal request	(PA# _____)	_____		
Name of office contact:			Specialty:	
Contact's phone number:			State license #:	
LTC facility contact/phone:			NPI:	MA Provider ID#:
RECIPIENT INFORMATION			Street address:	
Recipient Name:			Suite #:	City/state/zip:
Recipient ID#:	DOB:		Phone:	Fax:

CLINICAL INFORMATION

Medication requested: <input type="checkbox"/> Mozobil 24 mg/1.2 ml (20 mg/ml) injection			
Dose/directions:		Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):		Dx code (<i>required</i>):	
1. Does the Recipient have a diagnosis of non-Hodgkin's lymphoma or multiple myeloma?		<input type="checkbox"/> Yes → <i>submit documentation of diagnosis.</i> <input type="checkbox"/> No → <i>submit documentation of diagnosis and medical literature supporting the use of Mozobil for the Recipient's diagnosis.</i>	
2. Will the Recipient receive G-CSF (granulocyte-colony stimulating factor [Neupogen {filgrastim} or Zarxio {filgrastim-sndz}]) once daily for 4 days before receiving Mozobil?		<input type="checkbox"/> Yes <i>Submit documentation of Recipient's autologous stem cell treatment plan, including medications that will be used</i> <input type="checkbox"/> No	

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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