

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"/> Renewal request # of pages: _____		Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested: <input type="checkbox"/> Mozobil 24 mg/1.2 ml (20 mg/ml) injection <input type="checkbox"/> Mozobil _____	Beneficiary's weight:
Dose/directions:	Quantity: Refills:
Diagnosis (<i>submit documentation</i>):	Dx code (<i>required</i>):
1. Does the beneficiary have a diagnosis of non-Hodgkin's lymphoma, multiple myeloma, or other indication supported by nationally recognized compendia or consensus guidelines (e.g., NCCN)?	<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 beneficiary's diagnosis.</i>
2. Will the beneficiary receive G-CSF (granulocyte-colony stimulating factor, e.g., Neupogen, Zarxio, Granix) once daily for 4 days before receiving Mozobil? (**Note: All G-CSFs require prior authorization with Medical Assistance.)	<input type="checkbox"/> Yes <i>Submit documentation of beneficiary's autologous stem cell treatment plan, including medications that will be used.</i> <input type="checkbox"/> No
3. What is the planned date for the beneficiary's transplant?	Date: _____ <i>Submit documentation.</i>

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

Prescriber Signature:	Date:
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