pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

# MOZOBIL (plerixafor) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Mozobil (plerixafor)** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

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|---|---|---|---|
| ☐New request ☐Renewal request | # of pages: _____ | Prescriber name: | |
| Name of office contact: | | Specialty: | |
| Contact's phone number: | | NPI: | State license #: |
| LTC facility contact/phone: | | Street address: | |
| Beneficiary name: | | City/state/zip: | |
| Beneficiary ID#: | DOB: | Phone: | Fax: |

## CLINICAL INFORMATION

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|---|---|---|---|
| Drug requested: | ☐Mozobil 24 mg/1.2 ml (20 mg/ml) single-dose vial<br>☐Mozobil _____ | Beneficiary's weight: | |
| Dose/directions: | | Quantity: | Refills: |
| Diagnosis *(submit documentation)*: | | Dx code (*required*): | |

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| Does the beneficiary have a diagnosis of non-Hodgkin lymphoma, multiple myeloma, or other indication supported by nationally recognized compendia or consensus guidelines (e.g., NCCN, ASCO)? | ☐Yes → *Submit documentation of diagnosis.*<br>☐No → *Submit documentation of diagnosis and medical literature supporting the use of Mozobil for the beneficiary's diagnosis.* |
| Will the beneficiary receive a CSF (colony stimulating factor, e.g., filgrastim, pegfilgrastim, sargramostim) in addition to Mozobil? (Note: All CSFs require prior authorization with Medical Assistance.) | ☐Yes<br>☐No<br>*Submit documentation of beneficiary's hematopoietic cell mobilization treatment plan, including all drugs that will be used.* |
| If the beneficiary will be undergoing an autologous hematopoietic stem cell transplant, what is the planned date for the beneficiary's transplant (if known)? | Date: _____ *Submit documentation.* |

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

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|---|---|
| Prescriber Signature: | Date: |