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.

☐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

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

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.* ☐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) in addition to Mozobil? (Note: All CSFs require prior authorization with Medical Assistance.)	☐Yes ☐No *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

Prescriber Signature:	Date: