



Prior Authorization Form

MOZOBIL® (plerixafor)

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: [ ] Mozobil®
Date: \_\_\_\_\_ Patient ID#: \_\_\_\_\_ DOB: \_\_\_\_\_
Patient Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_
Prescribing Physician: \_\_\_\_\_ Office Contact: \_\_\_\_\_
Office Fax #: \_\_\_\_\_ Office Phone: \_\_\_\_\_

ONLY COMPLETED REQUESTS WILL BE REVIEWED

1. DIAGNOSIS FOR DRUG REQUESTED:

- [ ] Non-Hodgkin's Lymphoma
[ ] Multiple Myeloma
[ ] Other (specify) \_\_\_\_\_

2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

[ ] N/A If none or not applicable to diagnosis, indicate "N/A."

Table with 3 columns: Drug Name, Date, Duration. Includes blank lines for entry.

3. PATIENT HISTORY

a. Will the requested medication (Mozobil®) be used concurrently with a granulocyte colony stimulating factor to mobilize hematopoietic stem cells for collection and subsequent autologous transplantation?

[ ] Yes [ ] No [ ] N/A

Please add any other supporting medical information that may be useful in the decision-making process:

Blank lines for providing additional medical information.

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only
Document # \_\_\_\_\_ Coverage effective date / /
Processor Initials \_\_\_\_\_ Date \_\_\_\_\_
M F Rx coverage Y N STANDARD - SELECT LOB \_\_\_\_\_
Previous Auth Y N Approved Reviewer Initials \_\_\_\_\_ Date \_\_\_\_\_