AmeriHealth

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."

Drug Name	Date	Duration

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:

_____

_____

_____

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_____