Updated: 08/2019
DMMA Approved: 09/2019

Request for Prior Authorization for Mozobil® (plerixafor injection)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Mozobil® (plerixafor injection) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Mozobil (plerixafor injection) Prior Authorization Criteria:

For all requests for Mozobil® (plerixafor injection) all of the following criteria must be met:

- Member is 18 years of age or older.
- Medication must be prescribed by a bone marrow transplant specialist, hematologist, or oncologist.
- Member must have a diagnosis of either non-Hodgkin's lymphoma (NHL) or multiple myeloma (MM).
- Member must be a candidate for hematopoietic stem cell harvest for autologous stem cell transplantation.
- Medication must be used in combination with a granulocyte colony-stimulating factor (G-CSF)*.
- Member must not have a diagnosis of leukemia.
- The prescriber attests that female members of child-bearing age have been advised not to become pregnant when taking plerixafor injection.
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 4 days
- **Reauthorization criteria**
    - Member must meet initial prior authorization criteria
- **Reauthorization Duration of Approval:** 4 days

*Granulocyte colony-stimulating factor (G-CSF) medications may require a prior authorization.

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis (es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

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Mozobil® (plerixafor injection)
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

1) Is member 18 years of age or older?
☐ Yes ☐ No

2) Will the medication be prescribed by or in association with bone marrow transplant specialist, hematologist, or oncologist?
☐ Yes ☐ No

3) Which of the following diagnoses is the medication being used for:
☐ Non-Hodgkin's lymphoma (NHL)
☐ Multiple myeloma (MM)
Other:_____

4) Is the member a candidate for hematopoietic stem cell harvest for autologous stem cell transplantation?
☐ Yes ☐ No

5) Will the medication be used in combination with a granulocyte colony-stimulating factor (G-CSF)?
☐ Yes ☐ No

6) Does the member have a diagnosis of leukemia?
☐ Yes ☐ No

7) If member is female, does the prescriber attest that female members of child-bearing age have been advised not to become pregnant when taking plerixafor injection?
☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY			
Medication Name	**Strength/ Frequency**	**Dates of Therapy**	**Status (Discontinued & Why/Current)**

Prescribing Provider Signature	Date

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Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____ pounds or _____ kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE: _____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

*****Fill in questions as needed****** If you add content to this section that increases the request form to two pages, please have a section on page two that identifies which member the request is being submitted.

☐

☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Add questions as needed

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No
Please describe:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date

This page is only to be used if the form extends to a second page.

DRUG NAME

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PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
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PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

MEDICAL HISTORY (Complete for ALL requests)

*****Fill in questions as needed****** If you add content to this section that increases the request form to two pages, please have a section on page two that identifies which member the request is being submitted.

☐

☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Add questions as needed

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No
Please describe:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date