Updated: 10/2018
PARP Approved: 12/2018

Gateway Health
Prior Authorization Criteria

Mozobil® (plerixafor injection)

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

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

- Member is 18 years of age or older.
- 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 go meet initial prior authorization criteria
- **Reauthorization Duration of Approval:** 4 days

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

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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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 Gateway Health Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6253 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) Which of the following diagnoses is the medication being used for:
☐ Non-Hodgkin's lymphoma (NHL)
☐ Multiple myeloma (MM)
Other:_____

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

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

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

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

Prescribing Provider Signature	Date