Independence Blue Cross

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:

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

Internal use only			**Coverage effective date** / /		
Document #_______________________			Processor Initials___________	Date___________________	
M F Rx coverage	Y	N	STANDARD - SELECT	LOB____________________	
Previous Auth	Y	N	**Approved**	**Reviewer Initials**_____________	Date_____________

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