PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Mozobil

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is the prescribing physician an Oncologist or Hematologist? ☐ Yes ☐ No
Q2. For what use is this drug being prescribed? ☐ Stem cell mobilization for subsequent autologous transplantation ☐ Other
Q3. Please provide ICD code(s) for diagnosis.
Q4. Is the patient a new start to therapy? ☐ Yes ☐ No
Q5. Has the patient been diagnosed with non-Hodgkin's lymphoma? ☐ Yes ☐ No
Q6. Has the patient been diagnosed with multiple myeloma? ☐ Yes ☐ No

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Q7. Is Mozobil being used in combination with one of the following?

- ☐ Granulocyte colony stimulating factor (G-CSF) (e.g. filgrastim)
- ☐ Granulocyte macrophage colony stimulating factor (GM-CSF) (e.g. sargramostim)
- ☐ None of the above

Q8. Please select all that apply to the patient:

- ☐ Failure of prior standard stem cell mobilization procedures utilizing G-CSF or GM-CSF alone or in combination with chemotherapy
- ☐ High risk of poor mobilization (e.g. age > 60, radiation of pelvis, marrow involvement of disease, prior cytotoxic chemotherapy such as lenalidomide or fludarabine, low platelet count prior to mobilization)
- ☐ Use with "just-in-time" rescue or salvage therapy in case of suboptimal peripheral CD34+ count
- ☐ None of the above

Q9. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

- ☐ Pharmacy
- ☐ Individual prescriber
- ☐ Provider or specialty group
- ☐ Facility
- ☐ Other (please specify)

Q10. Provide name and NPI of the billing entity

Q11. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical ☐ Pharmacy

Q12. Additional Comments

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Prescriber Signature _____ Date _____

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.