MOZOBIL
Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.
Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES **PHONE 800-979-UPMC (8762)** **FAX 412-454-7722**

PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:	**Provider Specialty:**		
Provider First Name:	**Provider Last Name:**		
Provider Phone:	**Provider Fax:**	**Provider NPI #:**	
Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient DOB:**	**Patient Age:**
Drug Requested: ❑ Brand ❑ Generic	**Strength:**	**Frequency:**	**Qty Dispensed:**

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

❑ New Medication ❑ Ongoing Medication	**If Ongoing Provide Date Started:**	**If medication is ongoing, did the member show improvement while on therapy?**	❑ Yes ❑ No
Diagnosis:	**Date of diagnosis:**		

Place of administration? ❑Physician Office ❑Hospital/Facility	**Please indicate how medication will be billed:** ❑ Billed directly by the provider via JCODE Provide JCODE:_____ ❑ Billed by a pharmacy and delivered to the provider ❑ Billed by a pharmacy and delivered to the patient
Please provide facility/provider name and address:	

Medical History

Diagnosis: ❑**Multiple Myeloma** ❑**Non-Hodgkin's lymphoma** **Other:**_____

Does the member require hematopoietic stem cell mobilization for collection and subsequent autologous transplantation?	❑**Yes**	❑**No**
Will Mozobil be used in combination with G-CSF and initiated after the member has received G-CSF once daily for four days?	❑**Yes**	❑**No**
Will Mozobil be administered approximately 11 hours prior to the initiation of apheresis for up to 4 consecutive days?	❑**Yes**	❑**No**

Please provide any additional information which should be considered in the space below: