



**Hematological: Miscellaneous**  
**Mozobil (plerixafor) J2562,**  
**Nplate (romiplostim) J2796**  
**Prior Authorization Request**  
**Medicare Part B Form**

*Instructions: \* Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

<input type="checkbox"/>	<b>NEW START - Start Date:</b> _____	<input type="checkbox"/>	<b>Continuation</b> (within 365 days): Date of last treatment _____
<input type="checkbox"/>	Date Requested _____		
	Requestor _____	Clinic name: _____	Phone _____ / Fax _____

**MEMBER INFORMATION**

\*Name: \_\_\_\_\_ \*ID#: \_\_\_\_\_ \*DOB: \_\_\_\_\_

**PRESCRIBER INFORMATION**

\*Name: \_\_\_\_\_ MD FNP DO NP PA \*Phone: \_\_\_\_\_

\*Address: \_\_\_\_\_ \*Fax: \_\_\_\_\_

**DISPENSING PROVIDER / ADMINISTRATION INFORMATION**

\*Name: \_\_\_\_\_ Phone: \_\_\_\_\_

\*Address: \_\_\_\_\_ Fax: \_\_\_\_\_

**PROCEDURE / PRODUCT INFORMATION**

HCCP Code	Name of Drug <input type="checkbox"/> Self-administered	Dose (Wt: _____ kg Ht: _____ )	Frequency	End Date if known

Chart notes attached. **Other important information:** \_\_\_\_\_

**Diagnosis: ICD10:** \_\_\_\_\_ **Description:** \_\_\_\_\_

Provider attests the diagnosis provided is an FDA-Approved indication for this drug

**CLINICAL INFORMATION**

New Start or Initial Request: (Clinical documentation required for all requests)  
 **Provider has reviewed the attached “Criteria for Approval” and attests the member meets ALL required PA criteria.**  
 If not, please provide **clinical rationale** for formulary exception: \_\_\_\_\_

Continuation Requests: (Clinical documentation required for all requests)  
 **Provider has reviewed the attached “Criteria for Continuation” and attests the member meets ALL required PA Continuation criteria.**  
 Patient had an adequate response or significant improvement while on this medication.  
 If not, please provide clinical rationale for continuing this medication: \_\_\_\_\_

**ACKNOWLEDGEMENT**

**Request By (Signature Required):** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.**

## Prior Authorization Group – Hematologic: Misc. PA

### Drug Name(s):

NPLATE  
MOZOBIL

ROMIPILOSTIM  
PLERIXAFOR

### Criteria for approval of Prior Authorization Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Drug is being used appropriately per MCG GUIDELINES, CMS recognized compendia, authoritative medical literature, evidence-based guidelines and/or accepted standards of medical practice.
3. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.
  - If the member meets all these criteria, they may be approved by the Plan for the requested drug.
  - Quantity limits and Tiering will be determined by the Plan.

### Exclusion Criteria:

N/A

### Prescriber Restrictions:

N/A

### Coverage Duration:

Approvals will be for 12 months

### FDA Indications:

#### Nplate

- Hematopoietic subsyndrome of acute radiation syndrome
- Immune thrombocytopenia, In patients with insufficient response to corticosteroids, immunoglobulins, or splenectomy

#### Mozobil

- Harvesting of peripheral blood stem cells, In patients with non-Hodgkin lymphoma and multiple myeloma

### Off-Label Uses:

N/A

### Age Restrictions:

N/A

### Other Clinical Considerations:

N/A

### Resources:

[https://www.micromedexsolutions.com/micromedex2/librarian/CS/E86147/ND\\_PR/evidencexpert/ND\\_P/evidencexpert/DUPLICATIONSHIELDSYNC/BA39EC/ND\\_PG/evidencexpert/ND\\_B/evidencexpert/ND\\_AppProduct/evidencexpert/ND\\_T/evidencexpert/PFActionId/evidencexpert.GoToDashboard?docId=929249&contentSetId=100&title=Plerixafor&servicesTitle=Plerixafor&brandName=Mozobil&UserMdxSearchTerm=Mozobil&=null#](https://www.micromedexsolutions.com/micromedex2/librarian/CS/E86147/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/BA39EC/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.GoToDashboard?docId=929249&contentSetId=100&title=Plerixafor&servicesTitle=Plerixafor&brandName=Mozobil&UserMdxSearchTerm=Mozobil&=null#)

[https://careweb.careguidelines.com/ed24/ac/ac\\_03624.htm](https://careweb.careguidelines.com/ed24/ac/ac_03624.htm)