



Fax completed form to: (855) 840-1678
 If this is an URGENT request, please call (800) 882-4462
 (800.88.CIGNA)

Mozobil (plerixafor)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		
Urgency: <input type="checkbox"/> Standard <input type="checkbox"/> Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)					
Medication Requested: <input type="checkbox"/> Mozobil 24 mg/1.2 mL (20 mg/mL) vial <input type="checkbox"/> plerixafor 24 mg/1.2 mL (20 mg/mL) vial <input type="checkbox"/> Other (please specify):					
Directions for use:		Dose:	Quantity:	Duration of therapy:	
ICD10:					
Patient's current weight (kg):					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Other (please specify): <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Home Health / Home Infusion vendor <i>**Cigna's nationally preferred specialty pharmacy</i> 					
<i>**Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.155.</i>					
Facility and/or doctor dispensing and administering medication: Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State, Zip Code): _____					
Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No					
What is your patient's diagnosis? <input type="checkbox"/> Hematopoietic Stem Cell Donors <input type="checkbox"/> Leukemia <input type="checkbox"/> Multiple Myeloma (MM) <input type="checkbox"/> Non-Hodgkin's lymphoma (NHL) <input type="checkbox"/> WHIM syndrome (Warts, Hypogammaglobulinemia, Infections, and Myelokathexis) <input type="checkbox"/> All other indications					
Clinical Information (if MM, NHL, or Hematopoietic Stem Cell Donors) Is the requested medication being prescribed by (or in consultation with) a hematologist or a stem cell transplant physician? <input type="checkbox"/> Yes <input type="checkbox"/> No (if MM or NHL) Is this drug being utilized for mobilization of hematopoietic stem cells for subsequent autologous transplantation? <input type="checkbox"/> Yes <input type="checkbox"/> No (if MM or NHL) Is this medication being used in combination with a granulocyte-colony stimulating factor (G-CSF)? Note: Filgrastim products are an example of a granulocyte-colony stimulating factor and include Granix (tbo filgrastim subcutaneous injection) and Neupogen (filgrastim subcutaneous injection and intravenous infusion), as well as related biosimilars. <input type="checkbox"/> Yes <input type="checkbox"/> No					

(if MM or NHL) Has the patient received (or will receive) a granulocyte-colony stimulating factor for 4 days after which Mozobil (plerixafor subcutaneous injection) will be given approximately 11 hours prior to initiation of each apheresis for up to 4 consecutive days? Yes No

(if Hematopoietic Stem Cell Donors) Is this drug being utilized for mobilization of hematopoietic stem cells for subsequent transplantation?

- Yes, for AUTOLOGOUS transplantation (in the same person)
 Yes, for ALLOGENEIC transplantation (in another person)
 No

(if AUTOLOGOUS) Is this medication being used in combination with a colony stimulating factor (CSF)? Note: Filgrastim products are an example of a colony stimulating factor and include Granix (tbo filgrastim subcutaneous injection) and Neupogen (filgrastim subcutaneous injection and intravenous infusion), as well as related biosimilars. Other examples are Neulasta (pegfilgrastim subcutaneous injection), and related biosimilars, and Leukine (sargramostim subcutaneous injection and intravenous infusion). Yes No

(if ALLOGENEIC) Is this medication being used in combination with filgrastim? Note: Filgrastim products include Granix (tbo filgrastim subcutaneous injection) and Neupogen (filgrastim subcutaneous injection and intravenous infusion), as well as related biosimilars. Yes No

(if Hematopoietic Stem Cell Donors) Has the patient received (or will receive) a colony stimulating factor for 4 days after which Mozobil (plerixafor subcutaneous injection) is given prior to initiation of each apheresis for up to 4 consecutive days? Yes No

Additional pertinent information

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature: _____ Date: _____

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