Cigna®

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:
☐ Standard ☐ 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:
☐ Mozobil 24 mg/1.2 mL (20 mg/mL) vial
☐ plerixafor 24 mg/1.2 mL (20 mg/mL) vial
☐ Other (please specify):

Directions for use: Dose: Quantity: Duration of therapy:
ICD10:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***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.*

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? ☐ Yes ☐ No

What is your patient's diagnosis?
☐ Hematopoietic Stem Cell Donors
☐ Leukemia
☐ Multiple Myeloma (MM)
☐ Non-Hodgkin's lymphoma (NHL)
☐ WHIM syndrome (Warts, Hypogammaglobulinemia, Infections, and Myelokathexis)
☐ other *(please specify):*

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? ☐ Yes ☐ No

(if MM or NHL) Is this drug being utilized for mobilization of hematopoietic stem cells for subsequent autologous transplantation? ☐ Yes ☐ 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. ☐ Yes ☐ 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 or Unknown

(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

Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket).

Additional pertinent information *(Please provide clinical support for the use of this drug in your patient (including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently).*

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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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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