

Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Mozobil (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.

Complete/review information, sign and date. Fax signed forms to Aetna Better Health Florida at **1-855-799-2554**.

When conditions are met, we will authorize the coverage of Mozobil (Medicaid).

Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Mozobil (plerixafor injection)

Other, specify drug \_\_\_\_\_

Quantity \_\_\_\_\_ Frequency \_\_\_\_\_ Strength \_\_\_\_\_

Route of administration \_\_\_\_\_ Expected length of therapy \_\_\_\_\_

Patient information

Patient name: \_\_\_\_\_

Patient ID: \_\_\_\_\_

Patient Group No.: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Patient phone: \_\_\_\_\_

Prescribing physician

Physician name: \_\_\_\_\_

Specialty: \_\_\_\_\_ NPI number: \_\_\_\_\_

Physician fax: \_\_\_\_\_ Physician phone: \_\_\_\_\_

Physician address: \_\_\_\_\_ City, state, zip: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_

Circle the appropriate answer for each question.

1. Is the patient 18 years of age or older? Y N

[If no, no further questions.]

2. Does the patient have a confirmed diagnosis (in diagnosis codes or medical records) of non-Hodgkin's lymphoma or multiple myeloma? Y N

[If no, no further questions.]

Note: Medication to be administered in combination with granulocyte-colony stimulating factor (eg. Neupogen, Leukine, Neulasta)]

3. Is the medication prescribed as a component of an autologous stem cell transplant mobilization protocol?

Y      N

Comments:

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I affirm that the information given on this form is true and accurate as of this date.

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Prescriber (Or Authorized) Signature

Date