AvMed

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-877-535-1391**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: plerixafor (Mozobil®) (J2562) (Medical)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Dosage and/or Quantity Limits:

A. **Quantity Limit (max daily/cycle dose) [NDC unit]:**
   a. plerixafor (Mozobil) 24 mg vial: 8 vials per 4 day treatment cycle
B. **Max Units (per dose and over time) [HCPCS Unit]:**
   a. 40 billable units per day [40mg daily maximum dose]
C. **Injection, plerixafor, 1 mg:** 1 billable unit = 1 mg

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 1 treatment cycle, Maximum 4 days

- ❑ Member is 18 years of age or older

AND

- ❑ Prescribed by or in consultation with a hematologist/oncologist

AND

- ❑ The member has been diagnosed with non-Hodgkin's lymphoma (NHL) or multiple myeloma

AND

- ❑ The provider intends to use plerixafor for hematopoietic stem cells (HSCs) collection to use in subsequent autologous transplantation

Planned Date of Transplant: _____

AND

- ❑ Use of plerixafor to begin after the member has received a granulocyte colony-stimulating factor (G-CSF), such as filgrastim, for 4 days (must submit recent chart notes/progress notes detailing planned treatment regimen)

AND

- ❑ Plerixafor, filgrastim, and apheresis will be continued up to a maximum of 4 days must submit recent chart notes/progress notes detailing planned treatment regimen)

AND

- ❑ The provider will adhere to the recommended dose per weight and indicates that dose below:
  - ❑ Patients ≤83 kg: 20 mg fixed dose **or** 0.24 mg/kg once daily for up to 4 consecutive days
  - ❑ atients >83 kg: 0.24 mg/kg once daily for up to 4 consecutive days; maximum dose: 40 mg daily

Reauthorization Approval: 1 treatment cycle, Maximum 4 days. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ The member continues to meet the diagnosis and dosing requirements in the initial criteria above

AND

- ❑ The member is not experiencing unacceptable toxicity from the drug. [Examples of unacceptable toxicity include the following: severe hypersensitivity reactions/anaphylaxis, hematologic effects (e.g. leukocytosis, thrombocytopenia); splenic enlargement/rupture, tumor cell mobilization etc.]

AND

- ❑ Patient has had only one previous treatment cycle for the planned transplant indicated in the initial criteria above

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Medication being provided by (check applicable box(es) below):

- ❑ **Physician's office** **OR** ❑ **Specialty Pharmacy – PropriumRx**

For urgent reviews: Practitioner should call AvMed's Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: 11/18/2021
REVISED/UPDATED: 2/4/2022