



**Kansas Medical Assistance Program**

P O Box 3571  
Topeka, KS 66601-3571  
Provider 1-800-933-6593  
Beneficiary 1-800-766-9012

**Plerixafor Injection (Mozobil®)  
Prior Authorization Request Form**

**Beneficiary Information**

Beneficiary Name: \_\_\_\_\_  
Beneficiary Medicaid ID #: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Billing Provider Information (Physician OR Facility)**

Billing Provider's Name: \_\_\_\_\_  
Provider Medicaid ID#: \_\_\_\_\_ Provider NPI#: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_  
Procedure Code Requesting: \_\_\_\_\_ Total # of Units Requested: \_\_\_\_\_

**Prescriber Information**

Prescriber's Name: \_\_\_\_\_  
Prescriber's Medicaid ID#: \_\_\_\_\_ Prescriber's NPI#: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

**Requested Information**

1. Please indicate the diagnosis for which Mozobil® is being prescribed (no diagnosis codes):  
\_\_\_\_\_  
\_\_\_\_\_
2. What specialty is the prescriber?  
Oncologist \_\_\_\_\_ Other (please specify) \_\_\_\_\_
3. Is the patient taking granulocyte-colony stimulating factor (G-CSF) concurrently?  
Yes \_\_\_\_\_ No \_\_\_\_\_
4. Does the patient have a diagnosis of leukemia?  
Yes \_\_\_\_\_ No \_\_\_\_\_

**NOTE: Female patients must NOT be pregnant when starting therapy with Mozobil® or become pregnant during therapy with Mozobil®. Female patients with reproductive potential must use effective contraceptive methods during Mozobil® use.**

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Completed form should be faxed to the Prior Authorization Unit at 1-800-913-2229.  
This form will be returned unprocessed if it is not completed in its entirety.**