Cancer Care Ontario
Action Cancer Ontario | eClaims

Eligibility Form

Plerixafor - Stem Cell Mobilization in non-Hodgkin's Lymphoma or Multiple Myeloma

(This form should be completed before the first dose is dispensed.)

1. Patient Profile

* Surname: .....
* Given Name: .....
* OHIN: ..... * Chart Number: .....
* Postal Code: .....
* Height (cm): ..... * Weight (kg): .....
* BSA (m^2): ..... * Gender: ○ Male ○ Female ○ Other
* Date of Birth: ....
  Day Month Year
* Site:
* Attending Physician (MRP- Most Responsible Physician): .....

Requested Prior Approval ☐ Yes * Patient on Clinical Trial ○ Yes ○ No

Other (specify): .....

Specify Arm:
○ Standard of care arm ○ Experimental arm
○ Blinded / Unknown

Prior Approval Request

* Select the appropriate prior approval scenario:

○ 1-Unknown primary (submit pathology report and clinic note)

- ○ 2-Clinical document review (identify the patient history that needs to be reviewed against eligibility criteria in Additional Comments below)
- ○ 3-Regimen modification - schedule (complete questions a and b)
- ○ 4-Regimen modification - drug substitutions (complete questions a and c)
- ○ 5-Withholding a drug in combination therapy from start of treatment (complete questions d, e and f)
- ○ 6-Maintenance therapy delay (submit clinic note)
- ○ 7-Prior systemic therapy clinical trials (complete question g)
- ○ 8-Modification due to supply interruption/drug shortage
- ○ Other (specify)

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All relevant supporting documentation must be submitted at the time of prior approval. Documentation may include a pathology report, clinic note, and/or CT scans.

a. Co-morbidities / toxicity / justification:

.....

b. Intended regimen schedule: .....

c. Intended regimen: .....

d. Drug(s) to be held: .....

e. Rationale for holding drug(s): .....

f. Intention to introduce drug at a later date? ☐ Yes

g. Prior clinical trial identifier (e.g., NCT ID, trial name) and treatment description (e.g., arm, drug/regimen): .....

h. Anticipated date of first treatment: .... Day Month Year

i. Additional comments:

2. Eligibility Criteria

Specify patient's indication for this request:

a) Non-Hodgkin's Lymphoma ○ Yes

b) Multiple Myeloma ○ Yes

The patient meets the following criteria:

Plerixafor will be used in combination with filgrastim to mobilize hematopoietic stem cells for subsequent autologous transplantation; AND ☐ Yes

Select one of the following:

a) The patient has a PBCD34+ count of less than 10 cells/uL after 4 days of filgrastim; OR ○ Yes

b) Less than 50% of the target CD34+ yield is achieved on the first day of apheresis (after being mobilized by filgrastim alone or following chemotherapy); OR ○ Yes

c) If a patient has failed a previous stem cell mobilization with filgrastim alone or following chemotherapy ○ Yes

3. Funded Dose

Plerixafor 0.24mg/kg sc is given daily for a single mobilization attempt (maximum of 4 doses). The daily dose must not exceed 40mg.

4. Supporting Documents

None required for this policy.

In the absence of collecting supporting documentation:

- CCO reserves the right to perform an audit on the patient's eligibility to receive reimbursement for this policy.
- In the event of an audit, CCO may request a clinic note demonstrating:

    - Peripheral blood CD34+ count of less than 10 cells/uL after 4 days of filgrastim (e.g., a clinic note and flow cytometry report); OR
    - Less than 50% of the target CD34+ yield is achieved on the first day of apheresis after being mobilized with filgrastim alone or chemotherapy, (e.g., a clinic note and flow cytometry report.) Please specify the drug(s) used in the previous attempt and indicate the target CD34+ yield; OR
    - A clinic note documenting failure of a previous attempt at stem cell mobilization with filgrastim alone or following chemotherapy. The drug(s) used in the previous attempt must be specified.

- CCO reserves the right to recover the cost of treatment claims if the requested documentation is not provided.

Signature of Attending Physician (MRP-Most Responsible Physician): .....

....
Day Month Year