

Clinical Policy: Plerixafor (Mozobil)

Reference Number: PA.CP.PHAR.323

Effective Date: 01/2018

Last Review Date: 07/2023

[Coding Implications](#)[Revision Log](#)

Description

Plerixafor (Mozobil®) is a hematopoietic stem cell mobilizer.

FDA Approved Indication(s)

Mozobil is indicated in combination with granulocyte-colony stimulating factor (G-CSF) to mobilize hematopoietic stem cells (HSCs) to the peripheral blood for collection and subsequent autologous transplantation in patients with non-Hodgkin's lymphoma (NHL) and multiple myeloma (MM).

Policy/Criteria

It is the policy of PA Health & Wellness® that Mozobil is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Mobilization of Hematopoietic Stem Cells (must meet all):

1. Diagnosis of NHL or MM;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age \geq 18 years;
4. Prescribed in combination with G-CSF (e.g., Zarxio®);
**Prior authorization is (or may be) required for G-CSF*
5. Member is scheduled to receive autologous stem cell transplantation;
6. Mozobil is prescribed to be administered for up to 4 consecutive days;
7. Dose does not exceed one of the following (a or b):
 - a. Weight \leq 83 kg: 20 mg/day fixed dose or 0.24 mg/kg/day;
 - b. Weight $>$ 83 kg: 0.24 mg/kg (up to 40 mg per day).

Approval duration: 3 months

B. Other diagnoses/indications: Refer to PA.CP.PMN.53

II. Continued Therapy

A. Mobilization of Hematopoietic Stem Cells (must meet all):

1. Re-authorization is not permitted. Members must meet the initial approval criteria.

Approval duration: N/A

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via PA Health & Wellness benefit and documentation supports positive response to therapy or the Continuity of Care policy (PA.LTSS.PHAR.01) applies;
Approval duration: Duration of request or 3 months (whichever is less); or
2. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized)

III. Diagnoses/Indications for which coverage is NOT authorized

Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – PA.CP.PMN.53

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

G-CSF: granulocyte-colony stimulating factor

HSCs: hematopoietic stem cells

MM: multiple myeloma

NHL: non-Hodgkin lymphoma

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): hypersensitivity
- Boxed warning(s): none reported

V. Dosage and Administration

| Indication | Dosing Regimen | Maximum Dose |
|------------|--|--------------|
| NHL or MM | <p>The recommended dose of Mozobil by SC injection is based on actual body weight:</p> <ul style="list-style-type: none">• ≤ 83 kg: 20 mg fixed dose or 0.24 mg/kg of body weight• > 83 kg: 0.24 mg/kg of body weight <p>Initiate Mozobil treatment after the patient has received G-CSF once daily for 4 days. Administer Mozobil approximately 11 hours prior to initiation of each apheresis for up to 4 consecutive days.</p> <p>Use actual body weight to calculate the volume of Mozobil to be administered: $0.012 \times \text{actual body weight (in kg)} = \text{volume to be administered (in mL)}$.</p> <p>Mozobil dose and treatment if weight is more than 175% of ideal body weight have not been investigated.</p> | 40 mg/day |

VI. Product Availability

Single-use vial for injection: 1.2 mL of a 20 mg/mL solution containing 24 mg of plerixafor

VII. References

1. Mozobil Prescribing Information. Cambridge, MA: Genzyme Corporation; August 2020. Available at: www.mozobil.com. Accessed April 18, 2023.

2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed May 9, 2023.
3. National Comprehensive Cancer Network. Hematopoietic Cell Transplantation Version 1.2023. Available at: https://www.nccn.org/professionals/physician_gls/pdf/hct.pdf. Accessed: May 9, 2023.
4. Plerixafor Drug Monograph. Clinical Pharmacology. Available at: <https://www.clinicalkey.com/pharmacology>. Accessed May 9, 2023.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

| HCPSC Codes | Description |
|-------------|-----------------------------|
| J2562 | Injection, plerixafor, 1 mg |

| Reviews, Revisions, and Approvals | Date | Approval Date |
|--|---------|---------------|
| 4Q 2018 annual review: no significant changes; added prescriber requirement; references reviewed and updated. | 08/2018 | |
| 3Q 2019 annual review: No changes per Statewide PDL implementation 01-01-2020 | 07/2019 | |
| 3Q 2020 annual review: added age limit; added biosimilar Nivestym to list of G-CSF products which should be prescribed in combination with Mozobil; references reviewed and updated. | 07/2020 | |
| 3Q 2021 annual review: no significant changes; references reviewed and updated. | 07/2021 | |
| 3Q 2022 annual review: no significant changes; modified examples of G-CSF products to only indicate Zarxio which is the preferred product; references reviewed and updated. | 07/2022 | |
| 3Q 2023 annual review: no significant changes; separated the following requirement for additional clarity: Mozobil is prescribed to be administered for up to 4 consecutive days; references reviewed and updated. | 07/2023 | |