

**Clinical Policy: Motixafortide (Aphexda)**

Reference Number: LA.PHAR.655

Effective Date: 05.06.24

Last Review Date: 01.21.25 ~~0907-25-24~~

Line of Business: Medicaid

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

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

**\*\*Please note: This policy is for medical benefit\*\***

**Description**

Motixafortide (Aphexda®) is a hematopoietic stem cell mobilizer.

**FDA Approved Indication(s)**

Aphexda is indicated in combination with filgrastim (G-CSF) to mobilize hematopoietic stem cells (HSCs) to the peripheral blood for collection and subsequent autologous transplantation in patients with multiple myeloma (MM).

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**Policy/Criteria**

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of Louisiana Healthcare Connections that Aphexda is **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria****A. Mobilization of Hematopoietic Stem Cell** (must meet all):

1. Diagnosis of MM;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age ≥ 18 years;
4. Prescribed in combination with a formulary G-CSF (i.e., Zarxio®);  
*\*Prior authorization may be required for G-CSF.*
5. Member is scheduled to receive autologous stem cell transplantation;
6. Failure of plerixafor, unless contraindicated or clinically significant adverse effects are experienced;
- 6-7. Dose does not exceed one of the following (a or b):
  - a. The request meets both of the following (i and ii):
    - i. Dose does not exceed 1.25 mg per kg of actual body weight;
    - ii. Aphexda is prescribed to be administered for up to 2 doses per autologous stem cell transplantation;
  - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

*\*Prescribed regimen must be FDA-approved or recommended by NCCN*

**Approval duration: 3 months**

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255;
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to LA.PMN.53.

**II. Continued Therapy**

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

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

**Approval duration: Not applicable**

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255;
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to LA.PMN.53.

**III. Diagnoses/Indications for which coverage is NOT authorized:**

- A.** 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 policies – LA.PMN.53 for Medicaid or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

FDA: Food and Drug Administration

G-CSF: granulocyte-colony stimulating

factor

—factor

HSCs: hematopoietic stem cells

MM: multiple myeloma

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.*

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Plerixafor (Mozobil®)	The recommended dose of Mozobil by SC injection is based on actual body weight: <ul style="list-style-type: none"> <li>• ≤ 83 kg: 20 mg fixed dose or 0.24 mg/kg of body weight</li> <li>• &gt; 83 kg: 0.24 mg/kg of body weight</li> </ul> Initiate Mozobil treatment after the patient has received G-CSF once daily for 4 days.	40 mg/day

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Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	<p>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:  <math>0.012 \times \text{actual body weight (in kg)} = \text{volume to be administered (in mL)}</math>.</p> <p>Mozobil dose and treatment if weight is more than 175% of ideal body weight have not been investigated.</p>	

*Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.*

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): history of serious hypersensitivity reaction to Aphexda
- Boxed warning(s): none reported

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
MM	<p>The recommended dose of Aphexda is 1.25 mg/kg actual body weight.</p> <p>Initiate Aphexda treatment after filgrastim has been administered daily for 4 days. Administer Aphexda via slow (approximately 2 minutes) subcutaneous injection 10 to 14 hours prior to the initiation of the first apheresis.</p> <p>A second dose of Aphexda can be administered 10 to 14 hours before a third apheresis, if necessary.</p>	See dosing regimen

**VI. Product Availability**

Single-dose vial for injection: 62 mg of motixafortide as a lyophilized powder for reconstitution

**VII. References**

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1. Aphexda Prescribing Information. Waltham, MA: BioLineRx; September 2023. Available at: [www.aphexda.com](http://www.aphexda.com). Accessed ~~September 13, 2023~~ July 15, 2024.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: [https://www.nccn.org/professionals/drug\\_compendium/content/](https://www.nccn.org/professionals/drug_compendium/content/). Accessed ~~September 29, 2023~~ August 7, 2024.
3. National Comprehensive Cancer Network. ~~Multiple Myeloma Version 1.2024~~. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/myeloma.pdf](https://www.nccn.org/professionals/physician_gls/pdf/myeloma.pdf). Accessed ~~September 29, 2023~~.
4. ~~National Comprehensive Cancer Network~~. Hematopoietic Cell Transplantation Version ~~2.2023~~ 1.2024. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/hct.pdf](https://www.nccn.org/professionals/physician_gls/pdf/hct.pdf). Accessed ~~September 29, 2023~~ August 7, 2024.

### 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
J2277	Injection, motixafortide, 0.25 mg

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Converted corporate to local policy.	01.04.24	05.06.24
Added redirection to plerixafor; Added HCPSC code [J2277] and removed HCPSC codes [C3590, C9399].	07.25.24	<u>09.26.24</u>
<u>Annual review: no significant changes; references reviewed and updated.</u>	<u>01.21.25</u>	

### Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage

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