Clinical Policy: Motixafortide (Aphexda)

Reference Number: LA.PHAR.655
Effective Date: 05.06.24
Last Review Date: 12.22.25~~01.21.25~~
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~~Cells (must meet all)**:**

1. Diagnosis of MM;
2. Prescribed by or in consultation with an oncologist ~~or,~~ hematologist, or transplant specialist;
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~~;~~;
7. Dose does not exceed one of the following (a or b):
   a. ~~The request~~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~~off-label use policy LA.PMN.53.

II. Continued Therapy

A. Mobilization of Hematopoietic Stem ~~Cell (must meet all):~~Cells
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.~~off-label use policy 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 policy~~ies~~ 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
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~~plerixafor (Mozobil®)	The recommended dose of Mozobil by SC injection is based on actual body weight: • ≤ 83 kg: 20 mg fixed dose or 0.24 mg/kg of body weight • > 83 kg: 0.24 mg/kg of body weight	40 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	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. Use actual body weight to calculate the volume of Mozobil to be administered: 0.012 x actual body weight (in kg) = volume to be administered (in mL). Mozobil dose and treatment if weight is more than 175% of ideal body weight have not been investigated.	

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	The recommended dose of Aphexda is 1.25 mg/kg actual body weight. 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. A second dose of Aphexda can be administered 10 to 14 hours before a third apheresis, if necessary.	See dosing regimen

VI. Product Availability

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

VII. References

1. Aphexda Prescribing Information. Waltham, MA: BioLineRx; ~~September 2023.~~May 2025. Available at: www.aphexda.com. Accessed July ~~15, 2024~~17, 2025.

2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: https://www.nccn.org/professionals/drug_compendium/content/. Accessed August ~~7, 2024~~4, 2025.
3. National Comprehensive Cancer Network. Hematopoietic Cell Transplantation Version ~~1.2024~~2.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/hct.pdf. Accessed August ~~7, 2024~~4, 2025.

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.

HCPCS 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 HCPCS code [J2277] and removed HCPCS codes [C3590, C9399].	07.25.24	09.26.24
Annual review: no significant changes; references reviewed and updated.	01.21.25	03.17.25
Annual review: added transplant specialist as a prescriber option; references reviewed and updated	12.22.25	

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 decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy,

contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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