I. Medication Description

Mozobil™ (plerixafor) is an inhibitor of the CXCR4 chemokine receptor and blocks binding of its cognate ligand, stromal cell-derived factor-1a (SDF-1a). SDF-1a and CXCR4 are recognized to play a role in the trafficking and homing of human HSCs to the marrow compartment. Once in the marrow, stem cell CXCR4 can act to help anchor these cells to the marrow matrix, either directly via SDF-1a or through the induction of other adhesion molecules.

II. Position Statement

Coverage is determined through a prior authorization process with supporting clinical documentation for every request.

III. Policy

Coverage of Mozobil is available when the following criteria have been met:

- Member is at least 18 years of age AND
- The medication is prescribed by a hematologist/oncologist AND
- Mozobil is used in combination with one of the following colony stimulating factors:
  - Granulocyte colony stimulating factor (G-CSF): Neupogen (filgrastim), Zarxio (filgrastim-sndz), Granix (tbo-filgrastim) OR
  - Granulocyte macrophage colony stimulating factor (GM-CSF): Leukine (sargramostim) AND
- The requested use is supported by the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines (NCCN Guidelines®) and/or NCCN Drugs & Biologics Compendium (NCCN Compendium®) with a recommendation of category level 1 or 2A.

IV. Quantity Limitations

Coverage is provided for up to four daily doses at a maximum daily dosage of 0.24mg/kg (not to exceed 40mg per day).

V. Coverage Duration

The duration of authorization will be one month and in general will not be renewed.
VI. Coverage Renewal Criteria

One course of treatment will be authorized. Additional or repeat courses of therapy would be considered on a case by case basis.

VII. Billing/Coding Information

- J2562: 1 billable unit is 1mg
- 1.2ml vials containing 20mg/ml solution
- Pertinent indication - peripheral stem cell transplant: Z94.84

VIII. Summary of Policy Changes

- 3/1/11:
  - Requirement of: failure of mobilization utilizing colony stimulating factor alone, removed.
  - Addition of Warnings/Precautions
- 9/1/11:
  - Dosage recommendations amended to include information regarding body weight limits and hemodialysis.
  - Pregnancy Category D added to Warnings section.
- 9/15/12: no changes
- 9/15/13: Formatting changes; removal of warnings
- 9/15/14: dosing limits added based on weight
- 7/1/15: formulary distinctions made
- 9/15/15: no policy changes
- 7/19/16: no policy changes
- 6/21/17: coverage criteria updated to allow use as supported by current NCCN guidelines
- 6/15/18: no policy changes

IX. References


*These guidelines are not applicable to benefits covered under Medicare Advantage. Medicare Advantage benefit coverage requests are reviewed in accordance with the guidance set forth in Chapter 15 Section 50 of the Centers for Medicare & Medicaid Services Medicare Benefit Policy Manual.

The Plan fully expects that only appropriate and medically necessary services will be rendered. The Plan reserves the right to conduct pre-payment and post-payment reviews to assess the medical appropriateness of the above-referenced therapies.

The preceding policy is a guideline to allow for coverage of the pertinent medication/product, and is not meant to serve as a clinical practice guideline.