

Medical Policy:

Mozobil® (plerixafor)

POLICY NUMBER	LAST REVIEW	ORIGIN DATE
MG.MM.PH.156	March 17, 2025	

Medical Guideline Disclaimer Property of EmblemHealth. All rights reserved.

The treating physician or primary care provider must submit to EmblemHealth, or ConnectiCare, as applicable (hereinafter jointly referred to as “EmblemHealth”), the clinical evidence that the member meets the criteria for the treatment or surgical procedure. Without this documentation and information, EmblemHealth will not be able to properly review the request preauthorization or post-payment review. The clinical review criteria expressed below reflects how EmblemHealth determines whether certain services or supplies are medically necessary. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. Health care providers are expected to exercise their medical judgment in rendering appropriate care.

EmblemHealth established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). EmblemHealth expressly reserves the right to revise these conclusions as clinical information changes and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by EmblemHealth, as some programs exclude coverage for services or supplies that EmblemHealth considers medically necessary.

If there is a discrepancy between this guideline and a member's benefits program, the benefits program will govern. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and web site links are accurate at time of publication.

EmblemHealth may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice. EmblemHealth Services Company, LLC, has adopted this policy in providing management, administrative and other services to EmblemHealth Plan, Inc., EmblemHealth Insurance Company, EmblemHealth Services Company, LLC, and Health Insurance Plan of Greater New York (HIP) related to health benefit plans offered by these entities. ConnectiCare, an EmblemHealth company, has also adopted this policy. All of the aforementioned entities are affiliated companies under common control of EmblemHealth Inc.

Definitions

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

Length of Authorization

Coverage will be provided for one treatment cycle of four days and will be eligible for renewal for one additional treatment cycle.

Dosing Limits [Medical Benefit]

Max Units (per dose and over time) [Medical Benefit]:

48 billable units per day for 4 days

Guideline

I. Initial Approval Criteria

Mozobil may be considered medically necessary if the below conditions is met **AND** use is consistent with the medical necessity criteria that follows:

1. **Peripheral mobilization of stem cells for autologous transplantation**

- A. Patient is at least 18 years old; **AND**
- B. Patient is clinically diagnosed with non-Hodgkin’s lymphoma or multiple myeloma; **AND**
- C. Patient is preparing for autologous hematopoietic stem cell (HSC) transplant
- D. Mozobil is being used in conjunction with granulocyte-colony stimulating factor (G-CSF)

Limitations/Exclusions

Mozobil is not considered medically necessary for when any of the following selection criteria is met:

- 1. Course of therapy exceeds 4 consecutive days.

II. Renewal Criteria

- 1. Patient continues to meet INITIAL APPROVAL CRITERIA; **AND**
- 2. Patient has had only 1 previous treatment cycle; **AND**
- 3. Absence of unacceptable toxicity from the drug including severe hypersensitivity reactions/anaphylaxis, hematologic effects (e.g. leukocytosis, thrombocytopenia), splenic enlargement/rupture, tumor cell mobilization, etc.

Dosage/Administration

Indication	Dose
Peripheral mobilization of stem cells for autologous transplantation	<p>≤ 83 kg: 20-mg fixed dose or 0.24 mg/kg (actual body weight) subcutaneously approximately 11 hours prior to initiation of apheresis for up to 4 consecutive days; administer granulocyte-colony stimulating factor (G-CSF) 10 mcg/kg via subQ bolus or continuous infusion once daily in the morning for 4 days prior to the first evening dose of plerixafor, and on each day prior to apheresis</p> <p>> 83 kg: 0.24 mg/kg (actual body weight) subcutaneously approximately 11 hours prior to initiation of apheresis for up to 4 consecutive days; administer G-CSF 10 mcg/kg via subQ bolus or continuous infusion once daily in the morning for 4 days prior to the first evening dose of plerixafor, and on each day prior to apheresis; MAX dose of 40 mg/day</p>

Applicable Procedure Codes

Code	Description
J2562	Injection, plerixafor, 1 mg, 1 billable unit = 1 mg

Applicable NDCs

Code	Description
00024-5862-xx	Mozobil 24 mg/1.2 ml solution single use vial

ICD-10 Diagnoses

Code	Description
Z52.011	Autologous donor, stem cells

Z52.091	Other blood donor, stem cells
Z94.84	Stem cells transplant status

Revision History

Company(ies)	DATE	REVISION
EmblemHealth & ConnectiCare	03/17/2025	Annual Review: updated dosing limits, no criteria changes
EmblemHealth & ConnectiCare	2/1/2024	Annual Review: no criteria changes
EmblemHealth & ConnectiCare	6/5/2023	Annual review: removed ICD-10 Codes: Z52.001 and Z94.81
EmblemHealth & ConnectiCare	09/09/2022	Transferred policy to new template
EmblemHealth & ConnectiCare	07/15/2019	Annual review

References

1. Mozobil™ injection [package insert]. Cambridge, MA: Genzyme Corporation
2. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) plerixafor. National Comprehensive Cancer Network, 2019. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc. To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed April 2019.