Drug Coverage Policy

Effective Date 12/1/2025
Coverage Policy Number.....IP0597
Policy Title.....Aphexda

Hematology - Aphexda

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

OVERVIEW

Aphexda, a hematopoietic stem cell mobilizer, is indicated in combination with filgrastim (granulocyte colony stimulating factor [G-CSF]) to **mobilize hematopoietic stem cells to the peripheral blood for collection and subsequent autologous transplantation in patients with multiple myeloma**.[1]

Disease Overview

Multiple myeloma is a cancer formed by malignant plasma cells found in the bone marrow.[2,3] In 2023, it is estimated that there will be approximately 35,730 new cases of multiple myeloma and 12,590 deaths due to the disease. The condition is most frequently diagnosed in patients 65 years to 74 years of age, with 69 years as the median age of diagnosis. There are many therapies available for multiple myeloma. Autologous stem cell transplantation (ASCT) has a vital role in the treatment of multiple myeloma. The outcomes of ASCT relies on the collection of sufficient hematopoietic stem and progenitor cells, usually from peripheral blood.

Guidelines
Aphexda is addressed in the National Comprehensive Cancer Network guidelines for Hematopoietic Cell Transplantation (version 3.2025 – September 24, 2025).[4] Aphexda is listed as an alternative in combination with G-CSF to mobilize hematopoietic stem cells for autologous donors (category 2A) in patients with multiple myeloma; the regimen is more specific for filgrastim.

Coverage Policy

POLICY STATEMENT
Prior Authorization is required for benefit coverage of Aphexda. Approval is recommended for those who meet the **Criteria** and **Dosing** for the listed indication. Extended approvals are allowed if the patient continues to meet the Criteria and Dosing. Requests for doses outside of the established dosing documented in this policy will be considered on a case-by-case basis by a clinician (i.e., Medical Director or Pharmacist). All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with Aphexda, as well as the monitoring required for adverse events and long-term efficacy, the agent is required to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Aphexda is considered medically necessary when the following are met:

1. Multiple Myeloma. Approve for 1 month if the patient meets ALL of the following (A, B, C, D, AND E):
- A. Patient is ≥18 years of age; AND
- B. The agent is utilized for mobilization of hematopoietic stem cells for subsequent autologous transplantation; AND
- C. The medication is used in combination with filgrastim; AND
  Note: Examples of filgrastim products include Granix (tbo-filgrastim subcutaneous injection) and Neupogen (filgrastim subcutaneous injection and intravenous infusion), as well as related biosimilars.
- D. The medication is prescribed by a hematologist and/or a stem cell transplant specialist physician
- E. Preferred product criteria is met for the products listed in the below table(s)

Dosing. Approve up to two doses at 1.25 mg/kg given by subcutaneous injection.
Note: Aphexda is given 10 to 14 hours prior to the initiation of apheresis. A second dose can be administered 10 to 14 hours before a third apheresis.

Employer Plans:

Product	Criteria
Aphexda (motixafortide)	Approve if the patient meets **ONE** of the following: 1. Patient has tried plerixafor injection 2. Patient has already started therapy with Aphexda

Individual and Family Plans:

Product	Criteria
Aphexda (motixafortide)	Approve if the patient has meet **ONE** of the following: 1. Patient has tried plerixafor injection 2. Patient has already started therapy with Aphexda

Conditions Not Covered

Aphexda for any other use is considered not medically necessary, including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. **Leukemia.** Aphexda may cause mobilization of leukemia cells and subsequent contamination of the apheresis product.[1] Aphexda is not intended for hematopoietic stem cell mobilization and harvest in patients with leukemia.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Coding Information

Note: 1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

HCPCS Codes	Description
J2277	Injection, motixafortide, 0.25 mg (Code effective 04/01/2024)

References

1. Aphexda® subcutaneous injection [prescribing information]. Dublin, Ireland and Naples, FL: Ayrmid and Gamida; May 2025.
2. Cowan AJ, Green DJ, Kwok M, et al. Diagnosis and management of multiple myeloma. A review. JAMA. 2022;327(5):464-477.
3. The NCCN Multiple Myeloma Clinical Practice Guidelines in Oncology (version 2.2026 – July 16, 2025). © 2025 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed on October 4, 2025.
4. The NCCN Hematopoietic Cell Transplantation Guidelines in Oncology (version 3.2025 – September 24, 2025). © 2025 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed on October 4, 2025.

Revision Details

Type of Revision	Summary of Changes	Date
Annual Revision	No criteria changes	12/15/2024
Selected Revision	**Added HCPCS coding table:** **Added** J2277 (Code effective 04/01/2024)	12/27/2024
Annual Revision	**Policy Title.**	12/1/2025

	Updated from "Motixafortide" **to** "Hematology – Aphexda" **Multiple Myeloma.** **Added "**Note: Examples of filgrastim products include Granix (tbo-filgrastim subcutaneous injection) and Neupogen (filgrastim subcutaneous injection and intravenous infusion), as well as related biosimilars." **Preferred Product Table.** **Updated from** "Failure, Contraindication, or Intolerance to plerixafor injection" **to** "Approve if the patient has tried plerixafor injection"	

The policy effective date is in force until updated or retired.

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