blue california
Promise Health Plan

plerixafor (Mozobil)

Medical Benefit Drug Policy

Drug Details

USP Category: BLOOD PRODUCTS AND MODIFIERS
Mechanism of Action: Hematopoietic stem cell mobilizer, inhibitor of the CXCR4 chemokine receptor
HCPCS:
J2562:Injection, plerixafor, 1 mg
How Supplied:
24 mg/1.2 mL (20 mg/mL) in a single-dose vial

Condition(s) listed in policy *(see coverage criteria for details)*

- Peripheral Stem Cell Collection and Transplantation

Any condition not listed in this policy requires a review to confirm it is medically necessary. For conditions that have not been approved for intended use by the Food and Drug Administration (i.e., off-label use), the criteria outlined in the California Code of Regulations (CCR), Title 22, Section 51303 and 51313 must be met.

Special Instructions and Pertinent Information

Provider must submit documentation (such as office chart notes, lab results or other clinical information) to ensure the member has met all medical necessity requirements.

The member's specific benefit may impact drug coverage. Other utilization management processes, and/or legal restrictions may take precedence over the application of this clinical criteria.

Coverage Criteria
The following condition(s) require Prior Authorization/Preservice.

Peripheral Stem Cell Collection and Transplantation
Meets medical necessity if all the following are met:
1. Being used in combination with G-CSF [filgrastim (or biosimilars), or tbo-filgrastim, pegfilgrastim (or biosimilars)] with or without cyclophosphamide or disease-specific chemotherapy

Covered Doses:
Up to 0.24 mg/kg given subcutaneously daily for 4 days (not to exceed a maximum of 40 mg per day)

Coverage Period:
Once per stem cell transplant procedure

ICD-10:
Z52.011, Z52.091, Z94.84

References

1. Mozobil (plerixafor) Prescribing Information. Genzyme Corporation, Cambridge, MA. 9/2023.
2. National Comprehensive Cancer Network. Hematopoietic Cell Transplantation (Version 2.2025). Available by subscription at: www.nccn.org.

Review History

Date of Last Annual Review: 3Q2025

Changes from previous policy version:

- No clinical change following annual review.

Blue Shield of California Medication Policy to Determine Medical Necessity
Reviewed by P&T Committee