Mass General Brigham
Health Plan

Aphexda (motixafortide)
Effective 07/01/2025

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☐ Pharmacy Benefit ☒ Medical Benefit		
Specialty Limitations	N/A		
Contact Information	**Medical and Specialty Medications** All Plans | Phone: 877-519-1908 | Fax: 855-540-3693		
	Non-Specialty Medications All Plans | Phone: 800-711-4555 | Fax: 844-403-1029		
Exceptions	N/A		

Overview
Aphexda (motixafortide) is a hematopoietic stem cell mobilizer that is indicated in combination with filgrastim (G-CSF) to mobilize hematopoietic stem cells to the peripheral blood for collection and subsequent autologous transplantation in patients with multiple myeloma.

Aphexda is initiated after filgrastim has been administered daily for four days. Aphexda should be administered 10-14 hours before initiating apheresis. A second dose of Aphexda can be administered 10-14 hours before a third apheresis.

Coverage Guidelines
Authorization may be granted for members new to the plan within the past 90 days who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance program
OR
Authorization may be granted if the member meets all the following diagnosis-specific criteria:

1. Documented diagnosis of multiple myeloma
2. Member is 18 years of age or older
3. Documentation Aphexda is being used to mobilize hematopoietic stem cells for autologous transplantation
4. Documentation member has been approved by the Plan for autologous hematopoietic stem cell transplant
5. Aphexda will be used in conjunction with a granulocyte colony stimulating factor (G-CSF)
6. Member meets ONE of the following:
    a. Documentation member has had in inadequate response, adverse reaction, or contraindication to plerixafor
    b. Prescriber submits documentation of a clinical rationale why plerixafor is not clinically appropriate for the member

Continuation of Therapy

1. Requests for reauthorization must meet initial criteria.

Limitations

1. Initial and reauthorization approvals will be granted for three months.

References

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Review History

09/11/2024 – Reviewed at September P&T. Effective 11/01/2024.
04/09/2024 – Reviewed and Updated at April P&T. Updated criteria to clarify documentation requirements. Effective 07/01/2025.