HAUTE AUTORITÉ DE SANTÉ

The legally binding text is the original French version

TRANSPARENCY COMMITTEE

OPINION

16 December 2009

MOZOBIL 20 mg/ml, solution for injection
Box containing 1 vial (CIP: 397 153-7)

Applicant: GENZYME SAS

Plerixafor

ATC code: L03AX16

List I
Orphan medicinal product.
Medicine for hospital prescription only.
Medicine for restricted medical prescription (specialists in oncology and/or haematology) which requires special monitoring during treatment.

Date of Marketing Authorisation (centralised): 31 July 2009

Reason for request: Inclusion on the list of medicines approved for hospital use.

Medical, Economic and Public Health Assessment Division

1. CHARACTERISTICS OF THE MEDICINAL PRODUCT

1.1. Active ingredient
Plerixafor

1.2. Indication
"MOZOBIL is indicated in combination with G-CSF to enhance mobilisation of haematopoietic stem cells to the peripheral blood for collection and subsequent autologous transplantation in patients with lymphoma and multiple myeloma whose cells mobilise poorly."

1.3. Dosage
"MOZOBIL therapy should be initiated and supervised by a physician experienced in oncology and/or haematology. The mobilisation and apheresis procedures should be performed in collaboration with an oncology-haematology centre with acceptable experience in this field and where the monitoring of haematopoietic progenitor cells can be correctly performed.

Posology
The recommended dose of plerixafor is 0.24 mg/kg body weight/day.

It should be administered by subcutaneous injection 6 to 11 hours prior to initiation of apheresis following 4 day pre-treatment with granulocyte-colony stimulating factor (G-CSF). In clinical trials, MOZOBIL has been commonly used for 2 to 4 (and up to 7) consecutive days.

The weight used to calculate the dose of plerixafor should be obtained within 1 week before the first dose of plerixafor.

In clinical studies, the dose of plerixafor has been calculated based on body weight in patients up to 175% of ideal body weight. Plerixafor dose and treatment of patients weighing more than 175% of ideal body weight have not been investigated.

Ideal body weight can be determined using the following equations:
- male (kg): 50 + 2.3 x ((Height (cm) x 0.394) – 60);
- female (kg): 45.5 + 2.3 x ((Height (cm) x 0.394) – 60).

Based on increasing exposure with increasing body weight, the plerixafor dose should not exceed 40 mg/day.

Recommended concomitant medicinal products:
In pivotal clinical studies supporting the use of MOZOBIL, all patients received daily morning doses of 10 µg/kg G-CSF for 4 consecutive days prior to the first dose of plerixafor and on each morning prior to apheresis.

Special populations:

- Renal impairment: Patients with creatinine clearance 20-50 ml/min should have their dose of plerixafor reduced by one-third to 0.16 mg/kg/day. Clinical data with this dose adjustment are limited. There is insufficient clinical data experience to make alternative posology recommendations for patients with a creatinine clearance < 20 ml/min, as well as to make posology recommendations for patients on haemodialysis. Based on increasing exposure with increasing body weight the dose should not exceed 27 mg/day if the creatinine clearance is lower than 50 ml/min.

- Paediatric population: The experience in paediatric patients is limited. The safety and efficacy of MOZOBIL in paediatric patients have not been established in controlled clinical studies.

- Elderly patients (> 65 years old): No dose modifications are necessary in elderly patients with normal renal function. Dose adjustment in elderly patients with creatinine clearance ≤ 50 ml/min is recommended (see Renal impairment above). In general, care should be taken in dose selection for elderly patients due to the greater frequency of decreased renal function with advanced age."

2. COMPARABLE MEDICINAL PRODUCTS

2.1. ATC classification ATC (2009)

L : Antineoplastic and immunomodulating agents
L03 : Immunostimulants
L03A : Immunostimulants
L03AX : Other immunostimulants
L03AX16 : Plerixafor

2.2. Medicines in the same therapeutic category

First medicine in this therapeutic category.

2.3. Medicines with the same therapeutic aim

These are the other haematopoietic growth factors:

- Filgrastim: Neupogen and its generics, indicated for the "mobilisation of peripheral blood progenitor cells (PBPC)"
- Lenograstim: Granocyte indicated for the "mobilisation of peripheral blood haematopoietic progenitor cells"

Other alternative: sampling of haematopoietic stem cells in the bone marrow.

3. ANALYSIS OF AVAILABLE DATA

3.1. Efficacy

The efficacy and safety of MOZOBIL were evaluated in 8 studies:

- 3 comparative studies:
  - 2 phase III studies (pivotal studies 3101 and 3102): the aim of which was to compare the efficacy of combining MOZOBIL and G-CSF against G-CSF alone in terms of the mobilisation of haematopoietic stem cells in patients with non-Hodgkin's lymphoma (NHL) or multiple myeloma (MM).
  - 1 phase II study (2101): the aim of which was to compare the efficacy of combining MOZOBIL and G-CSF against G-CSF alone in terms of the mobilisation of haematopoietic stem cells in 25 patients with NHL or MM.
- 5 non-comparative studies:

- Initial mobilisation studies: study 2106, performed in 22 patients with Hodgkin's lymphoma and cohort study 2104, performed in 40 patients with NHL or MM; in view of the methods used in these studies (before/after study, no comparator, no statistical analysis, small population), they will not be examined in this Opinion.

- Mobilisation studies in patients whose cells mobilise poorly:
  - Phase II study (2102) performed in 20 patients with MM whose cells mobilise poorly: the aim of which was to evaluate the efficacy of MOZOBIL 240 µg/kg in combination with G-CSF 10 µg/kg administered for a maximum of 7 days in the process of mobilising and collecting CD34+ cells, which will be examined below.
  - Observational study 2109, performed in 5 patients with NHL or MM; in view of the small number of patients included in this study, no statistical analysis was made; it will therefore not be examined in this Opinion.
  - Study 2112, performed in 40 patients with NHL or MM or acute myeloid leukaemia. This study is currently in progress and only intermediate results are available; consequently, it will not be examined in this Opinion.

3.1.1. Initial mobilisation studies

- **Phase III studies: 3101 and 3102**

Method: Randomized, double-blind comparative phase III studies of MOZOBIL 240 µg/kg in combination with G-CSF (10 µg/kg) versus G-CSF (10 µg/kg) + placebo, in the context of the mobilisation and collection of CD34+ with a view to autologous transplantation, performed in 298 patients with non-Hodgkin's lymphoma (NHL) in study 3101 and 302 patients with multiple myeloma (MM) in study 3102.

Inclusion criteria: Patients who are 18 to 78 years of age and:
- have a confirmed diagnosis of NHL (study 3101) or MM (study 3102),
- are eligible for autologous transplantation,
- are in first or second partial or complete remission,
- at least 4 weeks since last cycle of chemotherapy,
- are in good general condition as defined by an ECOG status[1] of 0 or 1,
- have white blood cell count > 2.5 x 10^9/l, ANC (absolute neutrophil count) > 1.5 x 10^9/l, platelets > 100 x 10^9/l.

Exclusion criteria: in particular:
- failed previous hematopoietic stem cells mobilisation or collection attemps,
- prior allogenic or autologous transplantation,
- medullary invasion > 20% (study 3101).

Treatments:
Study 3101:
- G-CSF 10 µg/kg + MOZOBIL 240 µg/kg, n = 150,
- G-CSF 10 µg/kg + placebo, n = 148.

Study 3102:
- G-CSF 10 µg/kg + MOZOBIL 240 µg/kg, n = 148,
- G-CSF 10 µg/kg + placebo, n = 154.

Primary efficacy endpoint: Proportion of responders defined as the achievement of ≥ 5 x 10^6 CD34+/kg in 4 or fewer apheresis days (study 3101) and ≥ 6 x 10^6 CD34+/kg in 2 or fewer apheresis days (study 3102).

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Secondary endpoints: In particular, the proportion of non-responders achieving a transplant of < 2 x 10^6 CD34+/kg after less than 4 days of apheresis.

In these non-responders, a rescue procedure was proposed and the proportion of patients included in a rescue procedure achieving ≥ 2 x 10^6 CD34+/kg in 4 or fewer apheresis days was observed.

RESULTS:
The characteristics of the patients on inclusion were globally comparable, except in study 3101 where the patients were significantly older in the G-CSF + placebo group than in the MOZOBIL + G-CSF group (57.5 versus 55.1 years, p = 0.047).

Principal criterion: Results in intent to treat (cf. Table 1)

Table 1: Percentage of responders in 4 (3101) or 2 or fewer (3102) of apheresis days

	Study 3101 After < 4 apheresis days		Study 3102 After < 2 apheresis days	
	G-CSF 10 µg/kg + MOZOBIL 240 µg/kg n = 150	G-CSF 10 µg/kg + placebo n = 148	**G-CSF 10 µg/kg + MOZOBIL 240 µg/kg** n = 148	G-CSF 10 µg/kg + placebo n = 154
Number of responders (%)	**89 (59.3%)**	**29 (19.6%)**	**106 (71.6%)**	**53 (34.4%)**
Number of non-responders (%)	61 (40.7%)	119 (80.4%)	42 (28.4%)	101 (65.6%)
Difference (%) and 95% CI	**39.7 [29.6; 49.9]**		**37.2 [26.8; 47.6]**	
p	**< 0.001**		**< 0.001**	

In 4 (study 3101) or 2 (study 3102) or fewer apheresis days, the percentage of responders, defined as achieving ≥ 5 x 10^6 CD34+/kg (study 3101) and ≥ 6 x 10^6 CD34+/kg (study 3102), was significantly higher in the G-CSF + MOZOBIL group than in the group receiving G-CSF alone:

- Study 3101: 89 (59.3%) versus 29 (19.6%), p < 0.001,
- Study 3102: 106 (71.6%) versus 53 (34.4%), p < 0.001.

The patients included in these studies were not patients “whose cells mobilise poorly” as defined by the marketing authorisation for MOZOBIL.

Secondary endpoints:
In 4 or fewer apheresis days, the percentage of non-responders, defined as the achievement of < 2 x 10^6 CD34+/kg, was significantly lower in the G-CSF + MOZOBIL group than in the group receiving G-CSF alone:

- Study 3101: 20 (13.3%) versus 78 (52.7%), p < 0.001,
- Study 3102: 7 (4.7%) versus 18 (11.7%), p = 0.03.

These results for the superiority of the combination MOZOBIL + GCSF versus G-CSF alone were observed in first-line treatment in the context of the mobilisation of PSCs, which does not correspond to the marketing authorisation indication for MOZOBIL.

The efficacy data on the indication to be evaluated were obtained from subgroups of patients included in the rescue procedure, the results of which are presented below:

In study 3101, 62/98 non-responders were included in a rescue procedure: after a treatment-free period of 7 days, these patients received G-CSF 10 µg/kg/jour for 4 days, combined with MOZOBIL 240 µg/kg on the fourth day. During this rescue phase, in 4 or fewer apheresis days, the proportion of responders, defined as the achievement of ≥ 2 x 10^6 CD34+/kg, was 4/10 patients in the group initially treated with G-CSF + MOZOBIL and 33/52 patients in the group initially treated with G-CSF alone, statistical analysis not available.

In study 3102, only 7/25 patients in the G-CSF group were included in a rescue procedure and all achieved ≥ 2 x 10^6 CD34+/kg after less than 4 days of apheresis.

In accordance with the marketing authorisation, MOZOBIL is indicated in combination with G-CSF for the mobilisation of haematopoietic stem cells after the failure of G-CSF alone; the interpretation of these results observed in patients most of whom received first-line treatment with the combination MOZOBIL + G-CSF poses a problem of transferability.

- **Phase II study: 2101**

Method: Randomized, open, crossover comparative phase II study of MOZOBIL 240 µg/kg in combination with G-CSF 10 µg/kg versus G-CSF 10 µg/kg, used in the context of the mobilisation and collection of CD34+ performed in 15 patients with non-Hodgkin's lymphoma (NHL) and 10 patients with multiple myeloma (MM).

Inclusion criteria: Patients who are 18 to 70 years of age and:
- have a confirmed diagnosis of NHL or MM,
- are in first or second partial or complete remission,
- have previously received no more than 3 cycles of chemotherapy,
- are in good general condition as defined by an ECOG[2] status of 0 or 1,
- have platelets > 100 x 10^9/l.

Treatments:
- G-CSF 10 µg/kg + MOZOBIL 240 µg/kg.
- G-CSF 10 µg/kg alone.

Eighteen patients were treated with G-CSF alone then G-CSF + MOZOBIL; seven patients were treated with G-CSF + MOZOBIL then G-CSF alone.

Primary efficacy endpoint: Number of CD34+ cells collected.

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RESULTS: cf. Table 2

Table 2: Difference in the quantity of CD34+ cells collected in 4 or fewer apheresis days

	NHL n = 15		**MM** n = 10		**All** (NHL + MM) n = 25	
	MOZOBIL + G-CSF	**G-CSF**	**MOZOBIL + G-CSF**	**G-CSF**	**MOZOBIL + G-CSF**	**G-CSF**
Total quantity of CD34+ cells collected ($x10^6$ cells/kg)						
Mean ± standard deviation	5.8 ± 2.7	2.8 ± 2.9	10.4 ± 5.9	6.3 ± 4.7	7.7 ± 4.7	4.2 ± 4.1
Median	5.5 [2.7–13.7]	1.5 [0–9.1]	7.9 [5.5–25.4]	4.9 [0.5–17.2]	6.6 [2.7–25.4]	4.3 [0–17.2]
Intra-patient **difference for plerixafor** *vs.* **G-CSF** ($x10^6$ cells/kg)						
Mean ± standard deviation	3.1 ± 4.04		4.1 ± 2.53		3.5 ± 3.49	
Median	2.7 [-3.9–13.0]		4.1 [0.1–8.2]		3.4 [-3.9–13.0)	
p (t test)*	0.011		< 0.001		< 0.001	
p (Wilcoxon test)*	0.005		0.002		< 0.001	

In 4 or fewer apheresis days, the number of CD34+ cells collected was significantly higher in the G-CSF + MOZOBIL group than in the group receiving G-CSF alone: mean difference 3.5 ± 3.49 $x10^6$ cells/kg, p < 0.001.

Patients were not included according to their status as “good” or “poor” mobilisers.

3.1.2. Study in patients whose cells mobilise poorly

- **Study 2102**

Method: Non-comparative phase II study evaluating the efficacy of MOZOBIL 240 µg/kg in conjunction with G-CSF 10 µg/kg administered for a maximum of 7 days in the context of the mobilisation and collection of CD34+ cells performed in 20 patients with MM whose cells mobilise poorly. These patients were divided into 2 groups:

- Group A: patients who are “poor mobilisers”[3], n = 10,
- Group B: patients predicted to be “poor mobilisers”[4], n = 10.

Inclusion criteria: Patients who are 18 to 75 years of age, have MM, whose cells mobilise poorly and who have:

- a cumulative doxorubicin dose of < 450 mg/m^2,
- platelet count ≥ 100 x 10^9/l,
- white blood cells > 2 x 10^9/l,
- haematocrit > 26%.

Efficacy endpoints: Change in the number of CD34+ cells (cells/µl) in the circulating blood.

3 Patients who are “poor mobilisers”: patients with a history of failure to collect a transplant (number of cells collected < 2 x 10^6 cells/kg).
4 Patients predicted to be “poor mobilisers” are patients in whom mobilisation of < 1 x 10^6 cells/kg is expected in view of a level of circulating CD34+ cells of between 5 and 12 cells/µl following chemotherapy and G-CSF (after leucocyte recovery) or their past history (heavy chemotherapy) with a platelet count of between 100 and 150 x 10^9/L before mobilisation.

RESULTS:

Table 3: Change in the number of CD34+ cells (cells/µl) in the circulating blood before and after treatment with MOZOBIL in combination with G-CSF

	Group A n = 10	**Group B** n = 10	**All** n = 20
On inclusion			
Mean ± standard deviation	1.9 ± 1.1	2.6 ± 1.6	2.3 ± 1.4
Median [min-max]	1.7 [0.8 – 4.5]	3.2 [0.4–4.9]	2.1 [0.4–4.9]
After treatment (before **1st** apheresis)			
Mean ± standard deviation	8.3 ± 8.0	7.0 ± 4.9	7.6 ± 6.5
Median [min-max]	5.8 [2.3–29.7]	7.7 [1.3–14.7]	6.0 [1.3–29.7]
Change before/after treatment			
Mean ± standard deviation	4.2 ± 1.9	2.9 ± 1.0	3.6 ± 1.6
Median [min-max]	4.0 [1.8–6.6]	3.0 [0.5–4.7]	3.0 [0.5–6.6]

After a maximum 7 days' treatment with MOZOBIL in conjunction with G-CSF, the number of CD34+ cells in the circulating blood was multiplied by 3.6 ± 1.6 (mean). Given the methods used in this study (before/after, non-comparative, small population), these results must be interpreted with care.

3.2. Adverse effects

Study 3101:

During the mobilisation period, adverse events were more common in the G-CSF + MOZOBIL group, 98/150 (65.3%) than in the G-CSF group, 60/145 (41.4%). The commonest adverse events (> 10%) were as follows:

- diarrhoea: 57/150 (38%) versus 9/145 (6.2%),
- nausea: 26/150 (17.3%) versus 8/145 (5.5%),
- injection site erythema: 44/150 (29.3%) versus 9/145 (6.2%),
- bone pain: 16/150 (10.7%) versus 10/145 (6.9%).

Study 3102:

During the mobilisation period, adverse events were more common in the G-CSF + MOZOBIL group, 95/147 (64.6%) than in the G-CSF group, 67/151 (44.4%). The commonest adverse events (> 10%) were as follows:

- diarrhoea: 27/147 (18.4%) versus 8/151 (5.3%),
- nausea: 24/147 (16.3%) versus 11/151 (7.3%),
- injection site erythema: 30/147 (20.4%) versus 5/151(3.3%).

Study 2101:

All patients had adverse events. The commonest adverse events (> 10%) were as follows:

- diarrhoea: 6/25 (24%) versus 1/25 (4%),
- injection site erythema: 4/25 (16%) versus 0.

Study 2102:

In this study, adverse events were observed in 19/20 patients (95%) treated with G-CSF + MOZOBIL. The commonest adverse events (> 10%) were as follows:

- injection site erythema: 16/20 (80%),
- gastrointestinal disorders: 5/20 (25%), of which diarrhoea 3/20 (15%).

3.3. Conclusion

The efficacy and safety of MOZOBIL 240 µg/kg in conjunction with G-CSF 10 µg/kg were evaluated in three comparative studies and one non-comparative study in patients with non-Hodgkin's lymphoma (NHL) or multiple myeloma (MM).

The dossier is based on two pivotal studies (3101 and 3102) which included patients with malignant haemopathies who were candidates for stem cell mobilisation as first-line treatment, which does not correspond to the profile of patients in the indication specified in the marketing authorisation for MOZOBIL (patients "whose cells mobilise poorly").

In these studies, in 4 or 2 or fewer apheresis days, the percentage of responders, defined as the achievement of ≥ 5 x 10^6 CD34+/kg (study 3101) and ≥ 6 x 10^6 of CD34+ cells/kg (study 3102), was significantly higher in the G-CSF + MOZOBIL group than in the group receiving G-CSF alone:

- study 3101: 89 (59.3%) versus 29 (19.6%), $p < 0.001$,
- study 3102: 106 (71.6%) versus 53 (34.4%), $p < 0.001$.

In these studies, the efficacy data on the indication to be evaluated are from subgroups of patients included in a rescue procedure:

In study 3101, 62/98 patients were included in a rescue procedure[5] and in 4 or fewer apheresis days, the percentage of responders, defined as the achievement of ≥ 2 x 10^6 CD34+/kg, was lower in the G-CSF + MOZOBIL group than in the group receiving G-CSF alone: 4/10 patients (40%) versus 33/52 patients (63.5%), statistical analysis not available.

In study 3102, only 7/25 patients in the G-CSF group were included in a rescue procedure and all achieved ≥ 2 x 10^6 CD34+/kg in 4 or fewer apheresis days.

In accordance with the marketing authorisation, since MOZOBIL is indicated in combination with G-CSF for the mobilisation of haematopoietic stem cells after the failure of G-CSF alone, the interpretation of these results observed in patients most of whom received first-line treatment with the combination of MOZOBIL + G-CSF poses a problem of transferability.

In study 2101, in 4 or fewer apheresis days, the number of CD34+ cells collected was significantly higher in the G-CSF + MOZOBIL group than in the group receiving G-CSF alone: mean difference 3.5 ± 3.49 x 10^6 cells/kg, $p < 0.001$.

In study 2102, after a maximum of 7 days of treatment with MOZOBIL in conjunction with G-CSF, the number of CD34+ cells in the circulating blood was multiplied by an average of 3.6 ± 1.6. Given the methods used in this study (before/after, non-comparative, small population) these results must be interpreted with care.

The commonest adverse events observed during these studies were as follows: injection site erythema, gastrointestinal disorders (diarrhoea, nausea).

5 Non-responders received, after a treatment-free period of 7 days, G-CSF 10 µg/kg/day for 4 days in conjunction with MOZOBIL 240 µg/kg from the fourth day onwards.

4. TRANSPARENCY COMMITTEE CONCLUSIONS

4.1. Actual benefit

The mobilisation of progenitor stem cells (PSCs) with a view to autologous transplantation is performed in life-threatening conditions.

MOZOBIL in combination with G-CSF is intended as a curative therapy to mobilise sufficient numbers of PSCs with a view to autologous transplantation in subjects whose cells mobilise poorly.

The efficacy/adverse effects ratio for MOZOBIL is high.

MOZOBIL is a second intent therapy.

Alternative medicinal products exist (remobilisation at a distance from the first mobilisation with G-CSF).

Public health benefit:

The public health burden caused by the mobilisation of progenitor stem cells (PSCs) with a view to transplantation is low.

The improvement in the mobilisation of PSCs with a view to autologous transplantation in patients with multiple myeloma or lymphoma, particularly where mobilisation with G-CSF fails, is a public health need which counts as an established public health priority (improvement in access to transplantation*).

For patients affected by the indication in the marketing authorisation (patients whose cells mobilise poorly), given that a biological criterion was demonstrated on the basis of a single, non-comparative clinical study in twenty patients who were “poor mobilisers” under G-CSF, and in the absence of data on morbidity and mortality, it is not expected that the medicinal product MOZOBIL in combination with G-CSF will have any additional impact on morbidity and mortality.

Consequently, in this indication there is no expected public health benefit for the medicinal product MOZOBIL in conjunction with G-CSF.

** Ministerial Circular on inter-regional schemes for the organisation of healthcare: circular DHOS 14/02/2007 on activities in organ transplants and transplants of haematopoietic stem cells*

The actual medical benefit of MOZOBIL in combination with G-CSF in patients with lymphoma or multiple myeloma whose progenitor stem cells mobilise poorly is substantial.

4.2. Improvement in actual benefit

In the mobilisation of haematopoietic stem cells in the peripheral blood before their collection with a view to autologous transplantation, MOZOBIL in combination with G-CSF offers a moderate improvement in actual benefit (IAB III) in patients with lymphoma or multiple myeloma whose cells mobilise poorly.

4.3. Therapeutic use

The transplantation of peripheral stem cells (PSCs) allows faster haematological recovery than the transplantation of bone marrow (BM) for neutrophils and almost platelets, probably because a peripheral collection after stimulation gives a better stem cell yield than a medullary collection.

Apheresis after stimulation with leucocyte growth factors (GRANOCYTE or NEUPOGEN) is a simpler procedure to carry out than bone marrow sampling: it can be done on an outpatient basis, at a distance from reperfusion, does not require a general anaesthetic, allows faster recovery of a sufficient number of platelets; this advantage is smaller for leucocyte recovery. Overall, the ancillary care is less substantial with PSCs than with BM, with faster haematological recovery.

If collection fails, defined as the achievement of less than 2 x 10^6 CD34+ cells/kg, remobilisation can be considered at a distance from the first one, using the aforementioned strategies.

As regards the available data, MOZOBIL (240 µg/kg) in combination with G-CSF (10 µg/kg) can be offered to patients with lymphoma or multiple myeloma whose cells mobilise poorly.

4.4. Target population

The target population for MOZOBIL consists of patients with non-Hodgkin's lymphoma or multiple myeloma who require mobilisation of the haematopoietic stem cells and whose cells mobilise poorly.

It can be estimated from the following data:

- According to epidemiological data from the report on sampling and transplantation activity for 2008 from the Biomedicine Agency[6], 2951 autologous transplants were carried out in 2008, corresponding to 75% of the population
- According to the experts, about 25% of these patients are poor mobilisers (75% are good mobilisers) of haematopoietic stem cells.

In 2008, the 2,951 transplants carried out concerned patients who were "good mobilisers".

Thus, the target population for MOZOBIL can be estimated at 983 patients a year.

4.5. Transparency Committee recommendations

The Transparency Committee recommends inclusion on the list of medicines approved for use by hospitals and various public services in the indication and at the dosages in the Marketing Authorisation.

Packaging: Appropriate for the prescription conditions

Request for a study:

At the request of the Ministry of Health, the Committee requests, within 18 months of inclusion on the list, the initiation of a study to ascertain the prescription conditions for MOZOBIL in France. If the European registry cannot meet this request, a specific study will have to be set up.

6 Report on sampling and Transplantation activity in France for 2008. Agence de Biomédecine www.agence-biomedecine.fr