UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 2347-1
Program	Prior Authorization/Medical Necessity
Medication	Xolremdi™ (mavorixafor)
P&T Approval Date	8/2024
Effective Date	10/15/2024

1. Background:

Xolremdi™ (mavorixafor) is a CXC chemokine receptor 4 antagonist indicated in patients 12 years of age and older with WHIM syndrome (warts, hypogammaglobulinemia, infections and myelokathexis) to increase the number of circulating mature neutrophils and lymphocytes.

2. Coverage Criteria[a]:

A. Initial Authorization

1. **Xolremdi** will be approved based on **all** of the following criteria:

   a. Diagnosis of WHIM (warts, hypogammaglobulinemia, infections and myelokathexis) syndrome

   -AND-

   b. Patient has a genotype-confirmed mutation of chemokine (C-X-C motif) receptor 4 (CXCR4) consistent with WHIM phenotype

   -AND-

   c. Patient has an absolute neutrophil count (ANC) less than or equal to 500 cells /µL

   -AND-

   d. Prescribed by or in consultation with **one** of the following:

      (1) Allergist
      (2) Geneticist
      (3) Hematologist
      (4) Immunologist

   Authorization will be issued for 12 months.

B. Reauthorization

1. **Xolremdi** will be approved based on **both** of the following criteria:

a. Documentation of positive clinical response [e.g., improvement in absolute neutrophil counts (ANC), improvement in absolute lymphocyte counts (ALC), reduction in infections] to **Xolremdi** therapy

-AND-

e. Prescribed by or in consultation with **one** of the following:

(1) Allergist
(2) Geneticist
(3) Hematologist
(4) Immunologist

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Notification and Supply limits may be in place.

4. References:

1. Xolremdi [package insert]. Boston, MA: X4 Pharmaceuticals, Inc.; April 2024.

Program	Prior Authorization/Medical Necessity- Xolremdi™ (mavorixafor)
Change Control	
8/2024	New program.