

UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 1454-1
Program	Prior Authorization/Notification
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:

<p>A. <u>Initial Authorization</u></p> <p>1. Xolremdi will be approved based on the following criterion:</p> <p style="padding-left: 40px;">a. Diagnosis of WHIM (warts, hypogammaglobulinemia, infections and myelokathexis) syndrome</p> <p style="text-align: center;">Authorization will be issued for 12 months.</p> <p>B. <u>Reauthorization</u></p> <p>1. Xolremdi will be approved based on the following criterion:</p> <p style="padding-left: 40px;">a. Documentation of positive clinical response to Xolremdi therapy</p> <p style="text-align: center;">Authorization will be issued for 12 months.</p> <p>^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.</p>

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.
- Medical Necessity and Supply limits may be in place.

4. References:

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

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Change Control	
8/2024	New program.