HIGHMARK HEALTH OPTIONS

Updated: 07/2025
DMMA Approved: 07/2025

Request for Prior Authorization for Xolremdi (mavorixafor)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Xolremdi (mavorixafor) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Xolremdi (mavorixafor) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of **Warts, Hypogammaglobulinemia, Immunodeficiency, Myelokathexis (WHIM) syndrome** and the following criteria is met:

- Confirmation of the diagnosis by genetic testing confirming pathogenic or likely pathogenic variants in the CXCR4 gene
- A baseline absolute neutrophile count (ANC) ≤ 400cells/μL or absolute lymphocyte count (ALC) ≤ 650 cells/μL
- Documentation of symptoms and complications associated with WHIM syndrome (e.g. warts, hypogammaglobulinemia, recurrent infections, and myelokathexis)
- Prescribed by or in consultation with an immunologist, hematologist, or dermatologist.
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines.
- Must be age-appropriate according to FDA-approved labeling, nationally recognized compendia, or evidence-based practice guidelines
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
    - Documentation of ONE of the following:
        - Improvement in ANC or ALC from baseline
        - Decrease in frequency or severity of infections since initiating therapy

Reauthorization Duration of Approval: 12 months

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XOLREMDI (MAVORIXAFOR) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (855) 476-4158**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon – Fri 8:00 am to 7:00 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE: _____
Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

Was the member's diagnosis confirmed by a genetic test? ☐ Yes ☐ No (please provide documentation or the test)
Please provide one of the following:

- Baseline ANC: _____
- Baseline ALC: _____

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced an improvement with treatment? ☐ Yes ☐ No
Please provide one of the following:

- Current ANC: _____
- Current ALC: _____

Has the member experienced a decrease in the frequency or severity of infections since initiating therapy? ? ☐ Yes ☐ No

Prescribing Provider Signature	Date