Pharmacy Drug Policy & Procedure

Policy Name:	Xolremdi (mavorixafor)	Policy#:	2773P

Purpose of the Policy

The purpose of this policy is to define coverage criteria for Xolremdi (mavorixafor)

Statement of the Policy

Health Alliance Medical Plans will approve the use of Xolremdi (mavorixafor) under the specialty pharmacy benefit if the following criteria are met.

Criteria

1. Coverage Criteria

1.1 Diagnosis of WHIM (warts, hypogammaglobulinemia, infections, and myelokathexis) syndrome confirmed by pathogenic and or likely pathogenic variants in the CXCR4 gene

1.2 Documentation of symptoms and complications associated with WHIM syndrome (e.g. warts, hypogammaglobulinemia, recurrent infections, and myelokathexis)

1.3 Documentation of member's baseline absolute lymphocyte count (ALC) and number of infections experienced within the last year

1.4 Age 12 years or older

1.5 Prescribed by or in consultation with an immunologist, geneticist, or hematologist

1.6 Baseline absolute neutrophil count (ANC) is ≤ 400 cells/μL

1.7 Review of clinical documentation and confirming that patient has met all of the above requirements for treatment completed by both a pharmacist and medical director

2. Managed Dose Limit

2.1 Maximum #120 capsules per 30 days

3. Approval Period

3.1 Initial: 12 months

3.2 Reauthorization: 12 months with documented improvement on therapy as indicated by reduced frequency, duration, or severity of infections, less frequent treatment with antibiotics, fewer warts, improved or stabilized clinical signs/symptoms, or improvement in ANC or ALC from baseline

CPT Codes	

HCPCS Codes	

References

1. Xolremdi (mavorixafor) [prescribing information]. Boston, MA: X4 Pharmaceuticals Inc; April 2024.

2. Badolato R, Alsina L, Bertrand Y, et al. Phase 3 randomized trial of mavorixafor, CXCR4 antagonist, in WHIM syndrome. Blood 2024; blood.2023022658

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