Louisiana Medicaid
Mavorixafor (Xolremdi™)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for mavorixafor (Xolremdi™).

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

Approval Criteria for Initiation of Therapy

- The recipient is 12 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of WHIM syndrome with genetically confirmed C*XCR4* pathogenic variants consistent with WHIM syndrome (must be **stated on the request**); **AND**
- The recipient has a baseline absolute neutrophil count (ANC) ≤400 cells/µL (ANC results must be **stated on the request**); **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a geneticist, hematologist, immunologist, or infectious disease specialist.

Approval Criteria for Continuation of Therapy

- The prescriber states on the request that the recipient is established on the medication with evidence of a positive response to therapy indicated by reduced frequency of infections or improved clinical signs of WHIM syndrome (e.g. absolute neutrophil count, absolute lymphocyte count)

Duration of approval for initiation and continuation of therapy: 12 months

References

Xolremdi (mavorixafor) [package insert]. Boston, MA: X4 Pharmaceuticals, Inc; April 2024. https://www.xolremdihcp.com/pdf/prescribing-information.pdf

Revision / Date	Implementation Date
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