UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1454-2
Program	Prior Authorization/Notification
Medication	Xolremdi® (mavorixafor)
P&T Approval Date	8/2024, 8/2025
Effective Date	11/1/2025

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 the following criterion:

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

   Authorization will be issued for 12 months.

B. Reauthorization

1. **Xolremdi** will be approved based on the following criterion:

   a. Documentation of positive clinical response to **Xolremdi** therapy

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

4. References:

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

Program	Prior Authorization/Notification - Xolremdi® (mavorixafor)
Change Control	
8/2024	New program.
8/2025	Annual review. Updated reference.