# SENTARA COMMUNITY PLAN
# (MEDICAID)

## PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

**Directions**: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

**Drug Requested: Xolremdi™** (mavorixafor)

**MEMBER & PRESCRIBER INFORMATION:** Authorization may be delayed if incomplete.

**Member Name:** _____

**Member Sentara #:** _____ **Date of Birth:** _____

**Prescriber Name:** _____

**Prescriber Signature:** _____ **Date:** _____

**Office Contact Name:** _____

**Phone Number:** _____ **Fax Number:** _____

**NPI #:** _____

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

**Drug Name/Form/Strength:** _____

**Dosing Schedule**: _____ **Length of Therapy**: _____

**Diagnosis:** _____ **ICD Code, if applicable:** _____

**Weight (if applicable):** _____ **Date weight obtained:** _____

**Recommended Dosing:**

- ≤ 50 kg: 300 mg (maximum 3 capsules) once daily
- >50 kg: 400 mg (maximum 4 capsules) once daily

**Quantity Limits:** 4 capsules once daily

**CLINICAL CRITERIA:** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

**Initial Authorization: 6 months**

- ❑ Member is 12 years of age or older
- ❑ Medication is prescribed by or in consultation with an immunologist, hematologist or medical genetics specialist

**(Continued on next page)**

- ❑ Member has a diagnosis of WHIM syndrome (warts, hypogammaglobulinemia, infections and myelokathexis)
- ❑ Member's diagnosis has been confirmed by genetic testing documenting a genotype-confirmed variant of CXCR4 consistent with WHIM syndrome **(must submit test results)**
- ❑ Provider must submit **BOTH** of the following results from within the last 30 days:
  - ❑ Baseline absolute neutrophil count (ANC) ≤ 400 cells/µL **(Note: If ANC is undetectable, please submit baseline white blood cell count ≤ 400 cells/µL)**
  - ❑ Baseline absolute lymphocyte count (ALC) ≤ 1,000 cells/µL
- ❑ Member exhibits at least **ONE** other clinical manifestation of disease associated with WHIM syndrome, including warts, hypogammaglobulinemia, frequent infections, myelokathexis, or monocytopenia **(must submit medical chart notes and lab test results for documentation)**
- ❑ Member will **NOT** use any other CXCR4 antagonists (i.e., plerixafor [Mozobil], motixafortide [Aphexda]) while taking the prescribed medication
- ❑ Member has had an unsuccessful trial of, or life-threatening reaction to, standard of care therapies for treatment of WHIM syndrome such as granulocyte-colony stimulating factor (G-CSF) or granulocyte-macrophage colony-stimulating factor (GM-CSF) medications, immunoglobulins (intravenous or subcutaneous), prophylactic antibiotic therapy, other CXCR4 antagonists (i.e., plerixafor [Mozobil]) **(verified by medical chart notes, lab test results and/or pharmacy claims)**
- ❑ Member has **NOT** received an HSC transplant
- ❑ Prescribed dosing will follow FDA guidelines for member's current weight as follows: ≤50 kg: 300 mg (3 capsules) once daily; >50 kg: 400 mg (4 capsules) once daily

**Reauthorization: 12 months.** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member continues to meet **ALL** initial authorization criteria
- ❑ Member has experienced an increase in absolute neutrophil count and absolute lymphocyte count as compared to pre-treatment level **(must submit current lab test results)**
- ❑ Member has experienced disease response to treatment defined by reduced frequency, duration, or severity of infections, less frequent treatment with antibiotics, fewer warts, or improved or stabilized clinical signs/symptoms of WHIM syndrome

**Medication being provided by Specialty Pharmacy – Proprium Rx**

***Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.***

**Previous therapies will be verified through pharmacy paid claims or submitted chart notes.***