US Family Health Plan
Prior Authorization Request Form for
Mavorixafor (Xolremdi)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Clinical documentation may be required for approval.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: ______________________ Physician Name: ______________________
Address: ______________________ Address: ______________________
______________________ ______________________
Sponsor ID # ______________________ Phone #: ______________________
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? ***Please choose*** *"No" if the patient did not previously have a TRICARE approved PA for the requested medication.*	☐ Yes (subject to verification) Proceed to question **7**	☐ No **Proceed to question 2**
2. Is the patient greater than or equal to 12 years of age?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Was the requested medication prescribed by an immunologist or hematologist?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a diagnosis of diagnosis of Warts, hypogammaglobulinemia, immunodeficiency, myelokathexis (WHIM) syndrome?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the patient's diagnosis been confirmed by genotype variant of CXCR4?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**

Question	Yes	No
6. Does the patient have an absolute neutrophil count (ANC) LESS THAN OR EQUAL TO 400 cells/microliter?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
7. Has documentation been provided to confirm that the patient has a positive clinical response defined as an improvement in absolute neutrophil count (ANC)? NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.	☐ Yes **Sign and date below**	☐ No Proceed to question **8**
8. Has documentation been provided to confirm that the patient has a positive clinical response defined as a decrease in infections? NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

______________________________ Prescriber Signature

______________ Date

[13 November 2024]