



**BlueCross
BlueShield**

Federal Employee Program

XOLREMDI

PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn: Clinical Services
Fax: 1-877-378-4727

Patient Information (required)				Provider Information (required)		
Date:				Provider Name:		
Patient Name:				Specialty:		NPI:
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:	State:	Zip:		City:	State:	Zip:
Patient ID:	R <input type="text"/>			Physician Signature:		
PHYSICIAN COMPLETES						

Xolremdi (mavoxiafor)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its entirety for processing

- Is this request for brand or generic? ☐ Brand ☐ Generic
- Will the patient need more than 400 mg per day? ☐ Yes* ☐ No
*If YES, please specify the requested quantity: _____ mg per day
- Does the patient have a diagnosis of WHIM syndrome? ☐ Yes ☐ No
WHIM: warts, hypogammaglobulinemia, infections and myelokathexis
- FEMALE Patient:** Is the patient of reproductive potential? ☐ Yes* ☐ No
*If YES, will the patient be advised to use effective contraception during treatment with Xolremdi and for 3 weeks after the last dose? ☐ Yes ☐ No
- Has the patient been on this medication continuously for the last **6 months** excluding samples? **Please select answer below:**
☐ **NO** – this is **INITIATION** of therapy, please answer the following question:
 - Does the patient have a confirmed genotype variant of CXCR4 consistent with WHIM syndrome? ☐ Yes ☐ No
 - Does the patient have an absolute neutrophil count (ANC) less than or equal to 400 cells per microliter (cells/ μ L)? ☐ Yes ☐ No☐ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
 - Has the patient had a clinical benefit from therapy, such as an increased ANC or ALC or a reduction in infections? ☐ Yes ☐ No



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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 minutes FASTEST AND EASIEST	Now you can get responses to drug Prior Authorization requests securely online. Online submissions may receive instant responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to Caremark.com/ePA .
Phone (4-5 minutes for response)	The FEP Clinical Call Center can be reached at (877)-727-3784 between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 days for response)	Fax the attached form to (877)-378-4727 . Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. <u>Please only fax the completed form once as duplicate submissions may delay processing times.</u>

faster...
easier...
better...

Introducing ePA! Online Prior Authorizations in minutes through **Caremark.com/ePA**. Sign up today!

CVS/caremark 