



State of Oklahoma
SoonerCare

Xpovio® (selinexor) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information

Pharmacy Billing (NDC: _____) Start Date (or date of next dose): _____

Dose: _____ Regimen: _____

Pharmacy Information

Pharmacy NPI: _____ Pharmacy Name: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information:

Diffuse Large B-Cell Lymphoma (DLBCL):

A. Is diagnosis relapsed or refractory DLBCL, not otherwise specified, including DLBCL arising from follicular lymphoma? Yes ___ No ___

B. Has member received ≥2 prior lines of systemic therapy? Yes ___ No ___

Multiple Myeloma

A. Is diagnosis relapsed or refractory multiple myeloma? Yes ___ No ___

B. Will selinexor be used in combination with dexamethasone? Yes ___ No ___

i. If yes, is disease refractory after ≥4 prior therapies including ≥2 proteasome inhibitors (PIs), ≥2 immunomodulatory agents, and an anti-CD38 monoclonal antibody? Yes ___ No ___

C. Will selinexor be used in combination with bortezomib and dexamethasone? Yes ___ No ___

i. If yes, has the member failed at least 1 prior therapy? Yes ___ No ___

D. Will selinexor be used in combination with daratumumab or daratumumab/hyaluronidase and dexamethasone? Yes ___ No ___

i. If yes, has the member failed at least 1 prior therapy? Yes ___ No ___

If diagnosis is not listed above, please indicate diagnosis: _____

Additional Information: _____

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PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

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Member Name: _____ Date of Birth: _____ Member ID#: _____

Criteria

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on selinexor? Yes ___ No ___
3. Has the member experienced adverse drug reactions related to selinexor therapy? Yes ___ No ___
If yes, please specify adverse reactions: _____

Additional Information: _____

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Prescriber Signature: _____ Date: _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

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