OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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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:***_____

Billing Provider 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. 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 dexamethasone? Yes☐ No☐
   - ☐ **If diagnosis is not listed above, please indicate diagnosis:**_____

Additional Information: _____

_____

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: _____

_____

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.*

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma**.