Xpovio (selinexor)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA. ☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Multiple myeloma ☐ Diffuse large B-cell lymphoma(DLBCL) ☐ Other diagnosis: _____ICD-10 Code(s): _____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Is this drug being prescribed to this patient as part of a treatment regimen specified within a sponsored clinical trial? ☐ Yes ☐ No

<u>For diagnosis of multiple myeloma, please answer the following</u>:
Is patient going to be using dexamethasone in combination with Xpovio? ☐ Yes ☐ No

Will patient also be treated with Velcade (bortezomib)? ☐ Yes ☐ No

Is patient's disease refractory to at least one prior therapy? ☐ Yes ☐ No

Is patient's disease refractory to no more than three prior therapies? ☐ Yes ☐ No

Does patient have systemic light chain amyloidosis? ☐ Yes ☐ No

Does patient have CNS involvement of their disease? ☐ Yes ☐ No

Is patient's disease refractory to at least two proteasome inhibitors (such as Ninlaro(ixazomib), Velcade(bortezomib), Kyprolis(carfilzomib))? ☐ Yes ☐ No Please submit chart documentation.

Is patient's disease refractory to at least two immunomodulatory agents (such as Revlimid (lenolidomide), Thalomid (thalidomide), Pomalyst (pomalidomide))? ☐ Yes ☐ No Please submit chart documentation.

Is patient's disease refractory to an anti-CD38 monoclonal antibody (such as Darzalex (daratumumab))? ☐ Yes ☐ No Please submit chart documentation.

<u>For diagnosis of diffuse large B-cell lymphoma(DLBCL), please answer the following</u>:

Has patient received at least 2, but no more than 5 previous systemic regimens for the of diffuse large B-cell lymphoma(DLBCL)? ☐ Yes ☐ No Please submit chart documentation.

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Does patient have mucosa-associated lymphoid tissue(MALT) lymphoma? □ **Yes** □ **No**

Does patient have composite lymphoma(Hodgkin lymphoma+non-Hodgkin lymphoma, or HL+NHL)? □ **Yes** □ **No**

Was patient's DLBCL transformed from a disease other than indolent non-Hodgkin lymphoma? □ **Yes** □ **No**

Does patient have primary mediastinal(thymic) large B-cell lymphoma(PMBL)? □ **Yes** □ **No**

Does patient have a known central nervous system(CNS) lymphoma? □ **Yes** □ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: *Not all drugs/diagnoses are covered on all plans. This request may be denied unless all required information is received.*

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811