US Family Health Plan
Prior Authorization Request Form for
selinexor tablets **(Xpovio)**

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**

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. Is the patient GREATER THAN or EQUAL to 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication being prescribed by or in consultation with an oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. For which indication is the requested medication being prescribed?	☐ Patient has relapsed or refractory multiple myeloma who has received at least four prior therapies - Proceed to question **6** ☐ Relapsed or refractory diffuse large B-cell lymphoma (DLBCL), not otherwise specified, including DLBCL arising from follicular lymphoma - Proceed to question **10** ☐ Patient has multiple myeloma who has received at least one prior therapy - Proceed to question **11** ☐ Other - Proceed to question **4**	
4. Please provide the diagnosis.	_____ Proceed to question **5**	
5. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
6. Will Xpovio be used in combination with dexamethasone?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Has the patient tried and is refractory to at least TWO proteasome inhibitors (examples include bortezomib (Velcade) injection, carfilzomib (Kyprolis) infusion, ixazomib (Ninlaro) capsules)?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

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8. Has the patient tried and is refractory to at least TWO immunomodulatory drugs (examples include lenalidomide (Revlimid) capsules, pomalidomide (Pomalyst) capsules, thalidomide (Thalomid) capsules)?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Has the patient tried and is refractory to an anti-CD38 monoclonal antibody (for example, daratumumab (Darzalex) infusion)?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
10. Has the patient received at least two prior systemic therapies?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
11. Will Xpovio be used in combination with bortezomib and dexamethasone?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Will the patient be monitored for cytopenias including anemia, neutropenia, and thrombocytopenia?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Will the patient be monitored for electrolyte disturbances including hyponatremia and hypokalemia?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Will the patient be monitored for infection including upper respiratory infection and pneumonia?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Will the patient be monitored for dizziness and altered mental status?	☐ Yes Proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. What is the patient's age/gender?	☐ Male - Proceed to question **19** ☐ Female of reproductive age – Proceed to question **17** ☐ Female NOT of reproductive age – **Sign and date below**	
17. Is the patient pregnant or actively trying to become pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **18**
18. Will the patient breastfeed during treatment or within one week after the cessation of treatment?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **19**
19. Will the patient use effective contraception while taking this medication and for 1 week after cessation of therapy?	☐ 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