Prescriber Criteria Form Xpovio 2024 PA Fax 3121-A v1 010124.docx Xpovio (selinexor) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Xpovio (selinexor).

Drug Name: Xpovio (selinexor)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of multiple myeloma? [If no, then skip to question 3.]	Yes	No
2	Has the patient been treated with at least one prior therapy? [No further questions.]	Yes	No
3	Does the patient have a diagnosis of B-cell lymphoma? [If no, then no further questions.]	Yes	No
4	Is the B-cell lymphoma subtype ANY of the following: A) diffuse Large B-Cell Lymphoma (DLBCL), B) histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, C) acquired immunodeficiency syndrome (AIDS)-related B-cell lymphoma, D) high-grade B-cell lymphoma? [If no, then no further questions.]	Yes	No
5	Has the patient had at least two lines of systemic therapy?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ Date:_____