BlueCross BlueShield

XPOVIO PRIOR APPROVAL REQUEST

Send completed form to: Service Benefit Plan Prior Approval P.O. Box 52080 MC 139 Phoenix, AZ 85072-2080 Attn. Clinical Services Fax: 1-877-378-4727

Federal Employee Program. **PRIOR APPROVAL REQUEST** Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			Provider Information (required)			
Date:			Provider Name:			
Patient Name:			Specialty:		NPI:	
Date of Birth:	Sex: DMale	Gemale	Office Phone:		Office Fax:	
Street Address:	Office Street Address:					
City:	State:	Zip:	City:	St	ate:	Zip:
Patient ID: R	1 1 1	1 1	Physician Signature:			
PHYSICIAN COMPLETES						

Xpovio (selinexor)

**Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit

NOTE: Form must be completed in its entirety for processing

Is this request for brand or generic? Brand Generic

Will the patient need more than 96 tablets every 84 days? □Yes* □No

*If YES, please specify the requested quantity: ______ tablets every 84 days

1. Has the patient been on Xpovio continuously for the last 6 months, excluding samples? Please select answer below:

NO – this is **INITIATION** of therapy, please answer the following questions:

a. What is the patient's diagnosis?

□Multiple myeloma

i. Will Xpovio be used in combination with bortezomib and dexamethasone? Yes No

ii. Has the patient received at least one prior therapy? Yes No

Relapsed or refractory diffuse large B-cell lymphoma (DLBCL)

i. Has the patient received at least two prior lines of systemic therapy? Yes No

Relapsed or refractory multiple myeloma (RRMM)

i. Will Xpovio be used in combination with dexamethasone? Yes No

ii. Has the patient received at least four prior therapies? Yes No

iii. Is the patient's disease refractory to at least two *proteasome inhibitors? □Yes □No

*Proteasome Inhibitors: Kyprolis (carfilzomib), Ninlaro (ixazomib), Velcade (bortezomib)

iv. Is the patient's disease refractory to at least two *immunomodulatory agents? □Yes □No *Immunomodulatory Agents: Pomalyst (pomalidomide), Revlimid (lenalidomide), Thalomid (thalidomide)

v. Is the patient's disease refractory to an *anti-CD38 monoclonal antibody? *Anti-CD38 Monoclonal Antibody: Darzalex (daratumumab), Sarclisa (isatuximab-irfc)

Other diagnosis (*please specify*):_

YES – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

a. What is the patient's diagnosis?

□ Multiple myeloma

i. Will Xpovio be used in combination with bortezomib and dexamethasone? \Box Yes \Box No

Relapsed or refractory diffuse large B-cell lymphoma (DLBCL)

Relapsed or refractory multiple myeloma (RRMM)

i. Will Xpovio be used in combination with dexamethasone? \Box Yes \Box No

□Other diagnosis (*please specify*):_

b. Has the patient experienced disease progression or unacceptable toxicity while on Xpovio? Yes No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS



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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _

DOB: ___

____ Patient ID: R

2. Will the patient receive prophylactic treatment with a *5-HT3 antagonist and/or other anti-nausea agents prior to and during treatment with Xpovio? □Yes □No

*5-HT3 Antagonists: dolasetron (Anzemet), granisetron (Sustol, Sancuso), ondansetron (Zofran, Zuplenz), palonosetron (Aloxi)

- 3. Does the prescriber agree to monitor complete blood count (CBC), standard blood chemistry, and body weight? \Box Yes \Box No
- 4. **FEMALE Patient**: Is the patient of reproductive potential? □Yes* □No

**If YES*, will the patient be advised to use effective contraception during treatment with Xpovio and for one week after the final dose? \Box Yes \Box No

MALE Patient: Does the patient have a female partner of reproductive potential? Yes* No

**If YES*, will the patient be advised to use effective contraception during treatment with Xpovio and for one week after the final dose? \Box Yes \Box No

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The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Xpovio – FEP MD Fax Form Revised 5/9/2025