Prescriber Criteria Form

Xpovio 2025 PA Fax 3121-A v1 010125.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) Human Immunodeficiency Virus (HIV)-related B-cell lymphoma, D) high-grade B-cell lymphoma, E) post-transplant lymphoproliferative disorders? [If no, then no further questions.]	Yes ◯	No ◯
5	Has the patient been treated with 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:_____