STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

SELINEXOR

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
SELINEXOR	XPOVIO	45854		GPI-10 (2156006000)	

GUIDELINES FOR USE

1. Does the patient have a diagnosis of multiple myeloma (MM) and meet **ALL** of the following criteria?
   - The patient is 18 years of age or older
   - The requested medication will be used in combination with bortezomib (Velcade) **AND** dexamethasone
   - The patient has received at least one prior therapy

   If yes, **approve all of the following for 12 months by GPID or GPI-14:**
   - **40 mg once weekly dose: #4 per 28 days.**
   - **60 mg once weekly dose: #4 per 28 days.**
   - **80 mg once weekly dose: #8 per 28 days.**
   - **100 mg once weekly dose: #8 per 28 days.**

   If no, continue to #2.

2. Does the patient have a diagnosis of relapsed or refractory multiple myeloma (RRMM) and meet **ALL** of the following criteria?
   - The patient is 18 years of age or older
   - The requested medication will be used in combination with dexamethasone
   - The patient has received at least four prior therapies for the treatment of RRMM
   - The patient's RRMM is refractory to **ALL** of the following:
     - Two proteasome inhibitors (e.g., bortezomib [Velcade], carfilzomib [Kyprolis])
     - Two immunomodulatory agents (e.g., lenalidomide [Revlimid], pomalidomide [Pomalyst])
     - One anti-CD38 monoclonal antibody (e.g., daratumumab [Darzalex])

   If yes, **approve all of the following for 12 months by GPID or GPI-14:**
   - **60 mg once weekly dose: #4 per 28 days.**
   - **80 mg once weekly: #8 per 28 days.**
   - **100 mg once weekly dose: #8 per 28 days.**
   - **80 mg twice weekly (160 mg total per week) dose: #32 per 28 days.**

   If no, continue to #3.

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SELINEXOR

GUIDELINES FOR USE (CONTINUED)

3. Does the patient have a diagnosis of relapsed or refractory diffuse large B-cell lymphoma (DLBCL), not otherwise specified, including DLBCL arising from follicular lymphoma and meet **ALL** of the following criteria?
   - The patient is 18 years of age or older
   - The patient has received at least two lines of systemic therapy

   If yes, **approve all of the following for 12 months by GPID or GPI-14:**
   - **40 mg once weekly dose: #4 per 28 days.**
   - **60 mg once weekly dose: #4 per 28 days.**
   - **40 mg twice weekly (80 mg total per week) dose: #8 per 28 days.**
   - **60 mg twice weekly (120 mg total per week) dose: #24 per 28 days.**

   If no, do not approve.

   DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

   Our guideline named **SELINEXOR (Xpovio)** requires the following rule(s) be met for approval:
   A. You have ONE of the following diagnoses:
      1. Multiple myeloma (MM: a type of blood cancer)
      2. Relapsed or refractory multiple myeloma (RRMM: a type of blood cancer that returned or did not respond to treatment)
      3. Relapsed or refractory diffuse large B-cell lymphoma (DLBCL: a type of blood cancer), including DLBCL arising from follicular lymphoma

   B. You are 18 years of age or older
   C. **If you have multiple myeloma, approval also requires:**
      1. The requested medication will be used in combination with bortezomib (Velcade) and dexamethasone
      2. You have received at least one therapy before Xpovio

   D. **If you have relapsed or refractory multiple myeloma, approval also requires:**
      1. The requested medication will be used in combination with dexamethasone
      2. You have received at least four prior therapies for the treatment of RRMM)
      3. Your RRMM is refractory (non-responsive) to **ALL** of the following:
         a. Two proteasome inhibitors (such as bortezomib [Velcade], carfilzomib [Kyprolis])
         b. Two immunomodulatory agents (such as lenalidomide [Revlimid], pomalidomide [Pomalyst])
         c. One anti-CD38 monoclonal antibody (such as daratumumab [Darzalex])

   (Denial text continued on next page)

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SELINEXOR

GUIDELINES FOR USE (CONTINUED)

E. **If you have relapsed or refractory diffuse large B-cell lymphoma, approval also requires:**
   1. You have received at least two lines of systemic therapy (treatment that spreads throughout the body)

Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Monograph for Xpovio.

REFERENCES

- Xpovio [Prescribing Information]. Newton, MA: Karyopharm Therapeutics Inc.; July 2022.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 08/01/23
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P&T Approval: 01/21