Prior Authorization Request Form for
selinexor tablets **(Xpovio)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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?	☐ Relapsed or refractory multiple myeloma - Proceed to question **6** ☐ 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 **6**	☐ 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**
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 **10**	☐ No **STOP** **Coverage not approved**
10. Will the patient be monitored for cytopenias including anemia, neutropenia, and thrombocytopenia?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Will the patient be monitored for electrolyte disturbances including hyponatremia and hypokalemia?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Will the patient be monitored for infection including upper respiratory infection and pneumonia?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Will the patient be monitored for dizziness and altered mental status?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. What is the patient's age/gender?	☐ Male - Proceed to question **17** ☐ Female of reproductive age – Proceed to question **15** ☐ Female NOT of reproductive age – Proceed to question **17**	
15. Is the patient pregnant or actively trying to become pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **16**
16. Is the patient breast-feeding?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **17**
17. Will the patient take effective contraception during treatment and for 1 week after discontinuation?	☐ 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

[19 February 2020]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: