UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1296-6
Program	Prior Authorization/Notification
Medication	Xpovio® (selinexor)
P&T Approval Date	10/2019, 1/2021, 1/2022, 1/2023, 1/2024, 1/2025
Effective Date	4/1/2025

1. Background:

Xpovio (selinexor) is a nuclear export inhibitor indicated in combination with Velcade® (bortezomib) and dexamethasone for the treatment of adult patients with multiple myeloma who have received at least one prior therapy. It is also indicated in combination with dexamethasone for the treatment of adult patients with relapsed or refractory multiple myeloma (RRMM) who have received at least four prior therapies and whose disease is refractory to at least two proteasome inhibitors, at least two immunomodulatory agents, and an anti-CD38 monoclonal antibody. Xpovio is also indicated for the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma (DLBCL), not otherwise specified, including DLBCL arising from follicular lymphoma, after at least 2 lines of systemic therapy.

The National Cancer Comprehensive Network® (NCCN) also recommends the use of Xpovio for the treatment of previously treated multiple myeloma for relapsed or progressive disease in combination with Darzalex® (daratumumab) and dexamethasone, Kyprolis® (carfilzomib) and dexamethasone, or Pomalyst® (pomalidomide) and dexamethasone in patients who have received at least two prior therapies including an immunomodulatory agent and a proteasome inhibitor and who have demonstrated disease progression on or within 60 days of completion of the last therapy. The NCCN also recommends using Xpovio for the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma (DLBCL), not otherwise specified including histologic transformation of indolent lymphomas to DLBCL; HIV-related diffuse large B-cell lymphoma, or monomorphic B-cell hyper post-transplant lymphoproliferative disorder, after at least 2 lines of systemic therapy.

Coverage Information:
Members will be required to meet the criteria below for coverage. For members under the age of 19 years, the prescription will automatically process without a coverage review.

Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances. Some states also mandate usage of other Compendium references. Where such mandates apply, they supersede language in the benefit document or in the notification criteria.

2. Coverage Criteria[a]:

A. <u>Patients less than 19 years of age</u>

1. **Xpovio** will be approved based on the following criterion:

   a. Patient is less than 19 years of age

Authorization will be issued for 12 months.

B. Multiple Myeloma

1. **Initial Authorization**

a. **Xpovio** will be approved based on **one** of the following:

(1) **All** of the following:

a) Diagnosis of relapsed or refractory multiple myeloma (RRMM)

-AND-

b) Patient has received at least four prior therapies

-AND-

c) Disease is refractory to **all** of the following:

i. Two proteasome inhibitors (e.g., bortezomib, carfilzomib)
ii. Two immunomodulatory agents (e.g., lenalidomide, thalidomide)
iii. An anti-CD38 monoclonal antibody (e.g., daratumumab)

-AND-

d) Used in combination with dexamethasone

-OR-

(2) **All** of the following:

a) Diagnosis of multiple myeloma

-AND-

b) Patient has received at least one prior therapy

-AND-

c) **One** of the following:

i. Used in combination with Velcade® (bortezomib) and dexamethasone
ii. Used in combination with Darzalex® (daratumumab) and dexamethasone
iii. Used in combination with Kyprolis® (carfilzomib) and dexamethasone

-OR-

(3) **All** of the following:

a) Diagnosis of multiple myeloma

-AND-

b) Patient has received at least 2 prior therapies, including an immunomodulatory agent (e.g., lenalidomide, thalidomide) and a proteasome inhibitor (e.g., bortezomib, carfilzomib)

-AND-

c) Patient has demonstrated progression on or within 60 days of completion of the last therapy

-AND-

d) Used in combination with Pomalyst® (pomalidomide) and dexamethasone

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Xpovio** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Xpovio therapy

Authorization will be issued for 12 months.

C. Diffuse Large B-Cell Lymphoma (DLBCL)

1. **Initial Authorization**

a. **Xpovio** will be approved based on **both** of the following:

(1) **One** of the following:

a) Diagnosis of relapsed or refractory diffuse large B-cell lymphoma (DLBCL) (including histologic transformation of indolent lymphomas to DLBCL)

b) Diagnosis of relapsed or refractory HIV-related diffuse large B-cell lymphoma, primary effusion lymphoma, or HHV8-positive diffuse large B-cell lymphoma.

c) Diagnosis of relapsed or refractory monomorphic B-Cell type post-transplant lymphoproliferative disorder.

-AND-

(2) Patient has received at least 2 lines of systemic therapy

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Xpovio** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Xpovio therapy

Authorization will be issued for 12 months.

D. NCCN Recommended Regimens

The drug has been recognized for treatment of the cancer indication by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. Supply limits may be in place.
- Please refer to plan specifics to determine exclusion status.

4. References:

1. Xpovio [package insert]. Newton, MA: Karyopharm Therapeutics Inc.; July 2022.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org. Accessed November 25, 2024.

Program	Prior Authorization/Notification – Xpovio (selinexor)
Change Control	
10/2019	New program.
1/2021	Added coverage criteria for DLBCL according to label.
1/2022	Annual review. Updated coverage criteria for multiple myeloma according to label and NCCN. Updated references.
1/2023	Annual review. Updated background and coverage criteria for multiple myeloma according to NCCN recommendations. Added state mandate and updated references.
1/2024	Annual review. Updated background. Updated indicated formatting for consistency. Included coverage criteria for diffuse large B-cell lymphoma according to NCCN recommendations and updated reference.
1/2025	Annual review. Updated references.