MEDICAL MUTUAL®

Drug Policy

Policy:	Xpovio (selinexor)	Annual Review Date: 07/15/2021 Last Revised Date: 07/15/2021

OVERVIEW

Xpovio (selinexor) is a nuclear export inhibitor 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. It is also indicated for the treatment of relapsed or refractory diffuse large B-cell lymphoma (DLBCL), not otherwise specified, including DLBCL arising from follicular lymphoma, after the trial of at least 2 lines of systemic therapy. The approval was based on efficacy and safety in a prespecified subgroup analysis of 83 patients whose disease was refractory to bortezomib, carfilzomib, lenalidomide, pomalidomide, and daratumumab. The overall response rate was 25.3%. The median time to first response was 4 weeks (range: 1 to 10 weeks), and the median response duration was 3.8 months. For both indications, Xpovio was approved under accelerated approval based on response rate. Continued approval may be contingent upon verification in a confirmatory trial.

POLICY STATEMENT

This policy involves the use of Xpovio. Prior authorization is recommended for pharmacy benefit coverage of Xpovio. Approval is recommended for those who meet the conditions of coverage in the **Criteria and Initial/Extended Approval** for the diagnosis provided. **Conditions Not Recommended for Approval** are listed following the recommended authorization criteria. Requests for uses not listed in this policy will be reviewed for evidence of efficacy and for medical necessity on a case-by-case basis.

Because of the specialized skills required for evaluation and diagnosis of patients treated with Xpovio as well as the monitoring required for adverse events and long-term efficacy, initial approval requires Xpovio be prescribed by or in consultation with a physician who specializes in the condition being treated. In order to be considered for coverage, Xpovio must be prescribed by or in consultation with a hematologist or oncologist. All approvals for initial therapy are provided for the initial approval duration noted below.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Xpovio is recommended in those who meet the following criteria:

1. **Multiple Myeloma, Relapsed or Refractory**
   Criteria. *Patient must meet the following criteria (A, B, C, and D):*
   A. The patient is ≥ 18 years of age; AND
   B. The patient meets one of the following (i or ii):
      i. The patient meets all of the following:

a. The medication will be used in combination with dexamethasone; AND
b. The patient has received at least 4 prior therapies [documentation required]; AND
c. The cancer is refractory to all of the following (1, 2, and 3):
    1. At least two proteasome inhibitors (i.e. bortezomib, carfilzomib) [documentation required]; AND
    2. At least two immunomodulatory agents (i.e. lenalidomide, pomalidomide) [documentation required]; AND
    3. One anti-CD38 monoclonal antibody (i.e. daratumumab) [documentation required]; OR

ii. The patient has received at least ONE prior therapy AND will use Xpovio in combination with both dexamethasone and bortezomib (Velcade)

2. Diffuse Large B-Cell Lymphoma (DLBCL), relapsed or refractory
Criteria. *Patient must meet the following criteria (A and B):*

A. The patient is ≥ 18 years of age; AND
B. The patient has tried at least 2 lines of systemic therapies [documentation required]

3. Patients with another indication that is not listed but is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation
Criteria. *Prescriber will provide specific diagnosis for documentation. Approve.*

4. Patient has been started on Xpovio
Criteria. *Approve for an indication or condition addressed as an approval in this document.*

Initial Approval/ Extended Approval.
A) *Initial Approval:* 365 days
B) *Extended Approval:* 365 days

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Xpovio has not been shown to be effective, or there are limited or preliminary data or potential safety concerns that are not supportive of general approval for the following conditions. (Note: This is not an exhaustive list of Conditions Not Recommended for Approval).

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the drug provided or services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member and/or a

pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

REFERENCES

1. Xpovio tablets [prescribing information]. Newton, MA: Karyopharm Therapeutics Inc; April 2021.
2. Selinexor. In: DRUGDEX [online database]. Truven Health Analytics. Greenwood Village, CO. Last updated 5 July 2019. Accessed 10 July 2019.
3. The NCCN Drugs and Biologics Compendium. © 2021 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on 11 July 2021