HIGHMARK Delaware HEALTH OPTIONS

Updated: 07/2020
DMMA Approved: 08/2020

Request for Prior Authorization for Koselugo (selumetinib)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Koselugo (selumetinib) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Koselugo (selumetinib) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of neurofibromatosis type 1 (NF1) with symptomatic inoperable plexiform neurofibromas (PN) and the following criteria is met:

- Member must be between 2 and 18 years of age at start of therapy
- Prescribed by or in consultation with a neurologist or oncologist
- Body surface area is $\geq$ 0.55 m^2
- Member must have positive genetic testing for NF1 or one of the following:
    - Six or more caf-au-lait macules
    - Freckling in axilia or groin
    - Optic glioma
    - Two or more Lisch nodules
    - A distinctive bony lesion
    - A first-degree relative with NF1
- Member must have had at least on measureable PN, defined as a lesion $\geq$ 3 cm measured in one dimension.
- Complete resection of PN is not considered feasible without substantial risk or morbidity (e.g., due to encasement of, or close proximity to, vital structures, invasiveness, or high vascularity of the PN).
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
    - Member must have reduction or maintenance in PN volume at subsequent tumor assessments.
- **Reauthorization Duration of Approval:** 12 months

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Koselugo (selumetinib)
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: ____________pounds or ___________kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:

Is the member currently receiving requested medication? ☐ Yes ☐ No | Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_________________________

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Does member must have positive genetic testing for NF1? ☐ Yes ☐ No

Does the member have any of the following diagnostic criteria for NF1?

- Six or more caf-au-lait macules ☐ Yes ☐ No
- Freckling in axilia or groin ☐ Yes ☐ No
- Optic glioma ☐ Yes ☐ No
- Two or more Lisch nodules ☐ Yes ☐ No
- A distinctive bony lesion ☐ Yes ☐ No
- A first-degree relative with NF1 ☐ Yes ☐ No

Does the member have inoperable PN, defined as PN that cannot be surgically removed without risk for substantial morbidity?
☐ Yes ☐ No

REAUTHORIZATION

Does the member have reduction in PN volume at subsequent tumor assessment? Please provide clinical documentation?

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☐ Yes ☐ No	
SUPPORTING INFORMATION or CLINICAL RATIONALE	
Prescribing Provider Signature	Date