STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

SELUMETINIB

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
SELUMETINIB	KOSELUGO	46451		GPI-10 (2153356550)	

GUIDELINES FOR USE

1. Does the patient have a diagnosis of neurofibromatosis type 1 (NF1) and meet **ALL** of the following criteria?
   - The patient is 2 to 17 years of age
   - The patient has symptomatic, inoperable plexiform neurofibromas (PN)

   If yes, **approve for 12 months by GPID or GPI-14 for the requested strength with the following quantity limits:**
   - **Koselugo 10mg: #10 per day.**
   - **Koselugo 25mg: #4 per day.**

   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 **SELUMETINIB (Koselugo)** requires the following rule(s) be met for approval:
   A. You have neurofibromatosis type 1 (NF1: a genetic disorder that causes light brown skin spots and non-cancerous tumors to form on nerve tissue)
   B. You are 2 to 17 years of age
   C. You have symptomatic, inoperable (not treatable by surgery) plexiform neurofibromas (PN: tumors that grow from nerves anywhere in 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 Koselugo.

REFERENCES

- Koselugo [Prescribing Information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; April 2020.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 10/01/20
Created: 07/20
Client Approval: 08/20
P&T Approval: 07/20