Koselugo® (selumetinib)
Effective 01/01/2022

Plan	☐ MassHealth ☒ MH UPPL ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit (NLX)		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	**Specialty Medications**		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions	N/A		

Overview
Koselugo is indicated for treatment of neurofibromatosis type 1 in pediatric patients ≥2 years of age who have symptomatic, inoperable plexiform neurofibromas.

Coverage Guidelines
Authorization may be reviewed on a case by case basis for members new to AllWays Health Partners who are currently receiving treatment with Koselugo excluding when the product is obtained as samples or via manufacturer's patient assistance programs.

OR

Authorization may be granted for members when ALL the following criteria are met, and documentation is provided:

Plexiform neurofibromas (PN) in patients with neurofibromatosis type 1 (NF1)

Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis
2. Prescriber is a neurologist or oncologist
3. Appropriate dosing
4. Member is ≥ 2 years of age and < 18 years of age at the start of therapy
5. Member has at least one measurable plexiform neurofibroma with documentation that complete resection of PN is not feasible without substantial risk or morbidity†

†In the clinical trial, measurable PN were defined as a lesion ≥3 cm in one dimension. Documentation in medical records that note measurable lesion without specific dimensions may be approved.

Continuation of Therapy

Reauthorization will be granted when physician provides attestation of positive response to therapy.

Limitations

1. Initial approvals and reauthorizations will be granted for 12 months

Appendix

Appendix A: Exceeding Quantity Limitations

Requests exceeding the quantity limit should be evaluated on a case-by-case basis. If there is compelling rationale for exceeding the quantity limit, please forward to clinical review for case-by-case evaluation (e.g., stability, past approvals at a dose exceeding the quantity limit, specific clinical rationale for dose is documented).

In addition to criteria in the procedure table above, requests exceeding the quantity limit must have **ALL** of the following:

1. Dose is appropriate
2. Dose is consolidated
3. Appropriate clinical rationale for exceeding the quantity limit

Appendix B: Koselugo for Plexiform Neurofibromas in Adult Patients with Neurofibromatosis Type 1

Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis
2. Prescriber is a neurologist or oncologist
3. Appropriate dosing
4. Member has at least one measurable plexiform neurofibroma with documentation that complete resection of PN is not feasible without substantial risk or morbidity

References

1. Koselugo (selumetinib) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; December 2020.

Review History

11/17/2021 – Created and Reviewed for Nov P&T. Effective 1/01/2022; matched with MH UPPL. Effective 01/01/2022

Disclaimer

AllWays Health Partners complies with applicable federal civil rights laws and does not discriminate or exclude people on the basis of race, color, national origin, age, disability, or sex.