Koselugo® (selumetinib)
Effective 01/01/2022

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<th>Plan</th>
<th>Program Type</th>
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<td>☒ Prior Authorization</td>
<td>☒ Pharmacy Benefit</td>
<td>This medication has been designated specialty and must be filled at a contracted specialty pharmacy.</td>
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**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

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.