Koselugo (selumetinib)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Neurofibromatosis type 1 (NF1) ☐ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

INITIAL:

Does the patient have a body surface area greater than or equal to 0.55 m^2? ☐ **Yes** ☐ **No**

Can the patient swallow whole capsules? ☐ **Yes** ☐ **No**

Does the patient have a confirmed genetic test for NF1? ☐ **Yes** ☐ **No** (please submit documentation)

Does the patient have any of the following diagnostic criteria indicative of NF1:

- **Six or more café-au-lait macules (greater than or equal to 0.5 cm in pre-pubertal patients or greater than or equal to 1.5cm in post-pubertal patients)**
- **Freckling in the axilla or groin**
- **Optic glioma**
- **Two or more Lisch nodules**
- **A distinctive bony lesion (dysplasia of the sphenoid bone or dysplasia or thinning of long bone cortex)**
- **A first-degree relative with NF1**

☐ **Yes** ☐ **No** (please submit documentation)

Is the patient's disease inoperable such that it cannot be surgically completely removed without risk for substantial morbidity due to encasement of, or close proximity to, vital structures, invasiveness, or high vascularity of the PN?
☐ **Yes** ☐ **No** (please submit documentation containing rationale)

Does the patient have at least one lesion of at least 3cm measured in one dimension
☐ **Yes** ☐ **No** (please submit documentation)

Have the dimension(s) and location(s) of ALL measurable tumors been documented and submitted with this prior authorization request? ☐ **Yes** ☐ **No** (please submit measurements)

Does the patient always engage in age-appropriate self-care without assistance? ☐ **Yes** ☐ **No**

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RENEWAL

Has the patient's disease seen a ≥ 20% reduction in plexiform neurofibroma volume at a subsequent tumor assessment within the first 3-6 months of therapy, as supported by a submitted chart note documenting follow-up location(s) and dimensions(s) of ALL measurable tumors?

□ **Yes** □ **No** (please submit documentation of ALL measurable tumors)

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811