VENTURA COUNTY
HEALTH CARE PLAN

PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Koselugo Prior Authorization Policy
- Koselugo™ (selumetinib capsules – AstraZeneca Pharmaceuticals)

REVIEW DATE: 04/14/2021

OVERVIEW

Koselugo, a kinase inhibitor, is indicated for the treatment of pediatric patients 2 years of age and older with neurofibromatosis type 1 (NF1) who have symptomatic, inoperable plexiform neurofibromas.[1]

Koselugo is a mitogen-activated protein kinase kinases 1 and 2 (MEK1/2) inhibitor.[1]

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Koselugo. All approvals are provided for the duration noted below.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Koselugo is recommended in those who meet the following criteria:

FDA-Approved Indications

1. **Neurofibromatosis Type 1.** Approve for 3 years if the patient meets the following criteria (A and B):
   - **A)** The patient meets ONE of the following (i or ii):
     - **i.** Patient is 2 to 18 years of age; OR
     - **ii.** Patient is ≥ 19 years of age AND has been previously started on therapy with Koselugo prior to becoming 19 years of age; AND
   - **B)** Prior to starting Koselugo, the patient had symptomatic, inoperable plexiform neurofibromas, according to the prescriber.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Koselugo is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Koselugo™ capsules [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals; May 2020.