| Prescriber Criteria Form<br><br>Koselugo 2024 PA Fax 3771-A v1 010124.docx<br>Koselugo (selumetinib)<br>Coverage Determination |
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| This fax machine is located in a secure location as required by HIPAA regulations.<br>Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**.<br>Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process.<br>When conditions are met, we will authorize the coverage of Koselugo (selumetinib). |

| Drug Name:<br>Koselugo (selumetinib) |
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|---|---|---|
| **Patient Name:** | | |
| **Patient ID:** | | |
| **Patient DOB:** | **Patient Phone:** | |
| **Prescriber Name:** | | |
| **Prescriber Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Prescriber Phone:** | **Prescriber Fax:** | |
| **Diagnosis**: | **ICD Code(s):** | |

| **Please circle the appropriate answer for each question.** | | | |
|---|---|---|---|
| 1 | Does the patient have a diagnosis of neurofibromatosis type 1 (NF1)?<br>[If no, then skip to question 4.] | Yes | No |
| 2 | Is the request for a pediatric patient 2 years of age or older?<br>[If no, then no further questions.] | Yes | No |
| 3 | Does the patient have symptomatic, inoperable plexiform neurofibromas (PN)?<br>[No further questions.] | Yes | No |
| 4 | Does the patient have a diagnosis of pilocytic astrocytoma?<br>[If no, then no further questions.] | Yes | No |
| 5 | Does the patient have recurrent or progressive disease?<br>[If no, then no further questions.] | Yes | No |
| 6 | Does the patient have BRAF fusion or BRAF V600E activating mutation positive disease? | Yes | No |

| Comments: | _____ |
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| By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan. |
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**Prescriber (or Authorized) Signature: _____ Date:_____**