Prior Authorization Request Form for selumetinib (Koselugo)

JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1

Please complete patient and physician information (please print):

Patient Name: ______________________ Physician Name: ______________________
Address: ______________________ Address: ______________________
______________________ ______________________
Sponsor ID # ______________________ Phone #: ______________________
Date of Birth: Secure Fax #:

Step 2

Please complete the clinical assessment:

Question		
1. Is the requested medication prescribed by or in consultation with a hematologist or oncologist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have a diagnosis of neurofibromatosis type 1 (NF1) with symptomatic, inoperable plexiform neurofibromas?	☐ Yes Proceed to question **5**	☐ No Proceed to question **3**
3. Please provide the indication or diagnosis.	______________________ Proceed to question **4**	
4. Is the diagnosis from question 3 cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Will the patient be monitored for cardiomyopathy including a left ventricular functional assessment prior to initiation and at regular intervals during treatment?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Will the patient be monitored for ocular toxicity including retinal vein occlusion and retinal detachment via ophthalmic exams prior to initiation and at regular intervals during treatment?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Will the patient be monitored for gastrointestinal toxicity and will they receive co-administration of an anti-diarrheal if the patient develops loose stools?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

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Question		
8. Will the patient be monitored for severe skin rashes?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Will the patient be monitored for rhabdomyolysis?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Is the provider aware that Koselugo contains Vitamin E, which can increase bleeding risk if co-administered with a Vitamin K antagonist (for example, warfarin)?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Is the patient of childbearing potential?	☐ Yes Proceed to question **12**	☐ No **Sign and date below**
12. What is the patient's gender?	☐ Male – Proceed to question **13** ☐ Female – Proceed to question **14**	
13. Will the patient use effective contraception during treatment and for at least 1 week after the cessation of therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
14. Will the patient use effective contraception during treatment and for at least 1 week after the cessation of therapy?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **16**
16. Has it been confirmed that the patient is not pregnant by (-) HCG?	☐ Yes Proceed to question **17**	☐ No **STOP** **Coverage not approved**
17. Will the patient not breastfeed during treatment and for at least 1 week after the cessation of treatment?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge.

Please sign and date:

______________________________ Prescriber Signature

____________ Date

[11 November 2020]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: