Prescriber Criteria Form Koselugo 2026 PA Fax 3771-A v1 010126.docx Koselugo (selumetinib) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Koselugo (selumetinib).

Drug Name: Koselugo (selumetinib)

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)? [If no, then skip to question 4.]	Yes	No
2	Is the request for a pediatric patient 2 years of age or older? [If no, then no further questions.]	Yes	No
3	Does the patient have symptomatic, inoperable plexiform neurofibromas (PN)? [No further questions.]	Yes	No
4	Does the patient have a diagnosis of circumscribed glioma? [If no, then skip to question 7.]	Yes	No
5	Does the patient have recurrent or progressive disease? [If no, then no further questions.]	Yes	No
6	Does the patient have BRAF fusion or BRAF V600E activating mutation positive disease? [No further questions.]	Yes	No
7	Does the patient have a diagnosis of Langerhans cell histiocytosis (LCH)?	Yes	No

Comments:	

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.
Prescriber (or Authorized) Signature: _____ Date:_____