AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Koselugo	Page:	1 of 2
Effective Date:	3/31/2025	Last Review Date:	3/2025

Applies to:	☒Illinois	☐Florida	☐Michigan
	☒New Jersey	☒Maryland	☒Florida Kids
	☒Pennsylvania Kids	☐Virginia	☐Kentucky PRMD

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Koselugo under the patient's prescription drug benefit.

Description:

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indication
Koselugo 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 (PN).

B. Compendial Uses
1. Circumscribed glioma
2. Langerhans cell histiocytosis

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Koselugo

Policy/Guideline:

Coverage Criteria

A. Neurofibromatosis type 1
Authorization of 12 months may be granted for treatment of neurofibromatosis type 1 (NF1) when either of the following criteria are met:
1. Member is 2 years of age or older with symptomatic, inoperable plexiform neurofibromas (PN), or
2. The requested medication will be used as a single agent in members with recurrent or progressive NF-1 mutated glioma

B. Circumscribed Glioma
Authorization of 12 months may be granted as a single agent for treatment of recurrent or progressive circumscribed glioma with a BRAF fusion or BRAF V600E activating mutation.

C. Langerhans Cell Histiocytosis
Authorization of 12 months may be granted as a single agent for treatment of Langerhans cell histiocytosis.

Continuation of Therapy

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in the coverage criteria when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

Approval Duration and Quantity Restrictions:

Approval: 12 months

Quantity Level Limit:

- Koselugo (selumetinib) 10 mg capsules: 240 capsules per 30 days
- Koselugo (selumetinib) 25 mg capsules: 120 capsules per 30 days

References:

1. Koselugo [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; January 2024.
2. The NCCN Drugs & Biologics Compendium® © 2024 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed February 28, 2024.