ALBERTA BLUE CROSS®

SELUMETINIB
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta government sponsored drug programs.

PATIENT INFORMATION				COVERAGE TYPE
LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Coverage Criteria of Selumetinib (e.g. Koselugo)

Special authorization coverage may be provided for the treatment of pediatric patients between 2 and 18 years of age (inclusive), with neurofibromatosis type 1 (NF1) who have symptomatic, inoperable plexiform neurofibromas (PNs).

For coverage, this drug must be initiated and monitored by a Specialist in Oncology or Neurology.

- Coverage may be approved for up to a maximum daily dose of 100 mg for 18 months.
- Patients will be limited to receiving a one month supply of selumetinib per prescription at their pharmacy.

For continued coverage of this agent beyond 18 months, the patient must meet the following criteria:
1) The patient must be assessed by the Specialist after 18 months. The Specialist must confirm in writing that there is beneficial clinical effect (e.g., a reduction in pain, improved function, reduction in tumour volume, disease stabilization) using the Specialist's clinical judgement and/or standard imaging.

Following this assessment, continued coverage may be approved for up to a maximum daily dose of 100 mg for 12 months. Ongoing coverage may be considered if the patient is re-assessed by the Specialist every twelve months and is confirmed to be continuing to respond to therapy by meeting criteria as outlined in (1) above.

Selumetinib should be discontinued upon disease worsening or progression (e.g., worsening of motor function or pain).

Please provide the following information for ALL requests

Diagnosis
☐ Neurofibromatosis type 1 (NF1) with symptomatic, inoperable plexiform neurofibromas (PNs)
☐ Other, specify _____

Dosage and Frequency

For patients new to coverage but already on selumetinib, provide the treatment start date (YYYY-MM-DD) _____

Please provide the following information for RENEWAL requests and INITIAL requests for treatment-experienced patients

The patient has experienced beneficial clinical effect while on selumetinib (e.g., a reduction in pain, improved function, reduction in tumour volume, disease stabilization) using the Specialist's clinical judgement and/or standard imaging ☐ Yes ☐ No

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		Alberta Blue Cross, Clinical Drug Services **10009 108 Street NW, Edmonton, Alberta T5J 3C5** **FAX 780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST