

Clinical Policy: Selumetinib (**BrandName**)

Reference Number: CP.PHAR.464

Effective Date: **FDA Approval Date**

Last Review Date: 02.20

Line of Business: Commercial, HIM, Medicaid

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Selumetinib (**BrandName**[®]) is a mitogen-activated protein kinase enzyme 1/2 inhibitor.

FDA Approved Indication(s) [**Pending**]

BrandName is indicated for the treatment of paediatric patients with symptomatic neurofibromatosis type 1 (NF1) and inoperable plexiform neurofibromas (PNs).

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that **BrandName** is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria*

**Criteria will mirror the clinical information from the prescribing information once FDA-approved*

A. Neurofibromatosis Type 1 and Inoperable Plexiform Neurofibromas (must meet all):

1. Diagnosis of plexiform neurofibromas;*
2. Prescribed by or in consultation with an oncologist;
3. Age ≤ 18 and ≥ 3 years;*
4. Member has body surface area ≥ 0.55 m²; *
5. Member has at least one measurable plexiform neurofibroma, defined as a lesion ≥ 3 cm measured in one dimension;*
6. Member meets one of the following: positive genetic testing for neurofibromatosis type 1 or has at least one other diagnostic criterion for NF1 (*see Appendix D*);*
7. Complete resection is not considered to be feasible without substantial risk or morbidity; *
8. Dose does not exceed 2 capsules per day.*

Approval duration: 6 months*

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy*

**Criteria will mirror the clinical information from the prescribing information once FDA-approved*

A. Neurofibromatosis Type 1 and Inoperable Plexiform Neurofibromas (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving [**Brandname**] for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy as evidenced by decreased or maintained volume of plexiform neurofibromas from baseline;*
3. If request is for a dose increase, new dose does not exceed 2 capsules per day.*

Approval duration: 12 months*

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

NF1: Neurofibromatosis type 1

PN: plexiform neurofibroma

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings [Pending]

- Contraindication(s): **pending**
- Boxed warning(s): **pending**

Appendix D: NF1 Diagnostic Criterion [Pending]

- Six or more café-au-lait macules (greater than or equal to 0.5cm in prepubertal subjects or greater than or equal to 1.5 cm in post pubertal subjects)
- Freckling in axilla or groin
- Optic glioma
- Two or more Lisch nodules
- A distinctive bony lesion (dysplasia of the sphenoid bone or dysplasia or thinning of long bone cortex)

- A first-degree relative with NF1

V. Dosage and Administration [Pending]

Indication	Dosing Regimen	Maximum Dose
Neurofibroma	20mg/m ² PO BID with continuous dosing (1 cycle = 28 days)*	[Pending]

VI. Product Availability [Pending]

Pending

VII. References

1. Dombi E, Baldwin A, Marcus L, et al. Activity of selumetinib in neurofibromatosis type-1 related plexiform neurofibromas. N Engl J Med. 2016; 375(26): 2550-2560.
2. ClinicalTrials.gov. AZD6244 hydrogen sulfate for children with nervous system tumors. Available at https://clinicaltrials.gov/ct2/show/study/NCT01362803?show_desc=Y. Accessed January 9, 2020.
3. Gross AM, Wolters P, Baldwin A et al. SPRINT: Phase II study of the MEK ½ inhibitor selumetinib (AZD6244, ARRY142886) in children with neurofibromatosis type 1 (NF1) and inoperable plexiform neurofibromas (PN). Journal of Clinical Oncology. 2018; 36(15): 10503. Available from: http://ascopubs.org/doi/abs/10.1200/JCO.2018.36.15_suppl.10503. Accessed January 9, 2020.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	01.21.20	02.20

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy,

contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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