BRITISH COLUMBIA | Ministry of Health

SPECIAL AUTHORITY REQUEST

SELUMETINIB FOR PLEXIFORM NEUROFIBROMAS

HLTH 5836 2025/02/03

◯ **INITIAL - Complete sections 1 - 5, & 8** ◯ **RENEWAL - Complete sections 1 - 4, 6 - 8**

For up-to-date criteria and forms, please check: www.gov.bc.ca/pharmacarespecialauthority

Fax requests to 1-800-609-4884 (toll free) OR mail requests to: PharmaCare, Box 9652 Stn Prov Govt, Victoria, BC V8W 9P4
This facsimile is doctor-patient privileged and contains confidential information intended only for PharmaCare. Any other distribution, copying or disclosure is strictly prohibited.

If PharmaCare approves this Special Authority request, approval is granted solely for the purpose of covering prescription costs. PharmaCare approval does not indicate that the requested medication is, or is not, suitable for any specific patient or condition.

If you have received this fax in error, please write MISDIRECTED across the front of the form and fax toll-free to 1-800-609-4884, then destroy the pages received in error.

Forms with information missing will be returned for completion. If no prescriber fax or mailing address is provided, PharmaCare will be unable to return a response.

SECTION 1 – NEUROONCOLOGIST/PEDIATRICIAN INFORMATION

Name and Mailing Address	
College ID (use ONLY College ID number)	Phone Number (include area code)
CRITICAL FOR A TIMELY RESPONSE →	Neurooncologist/Pediatrician Fax Number

SECTION 2 – PATIENT INFORMATION

Patient (Family) Name	
Patient (Given) Name(s)	
Date of Birth (YYYY / MM / DD)	Date of Application (YYYY / MM / DD)
CRITICAL FOR PROCESSING →	Personal Health Number (PHN)

SECTION 3 – MEDICATION REQUESTED AND PATIENT BODY SURFACE AREA

SELUMETINIB (10 mg and 25 mg capsules)
PharmaCare provides coverage for a maximum dose/frequency of 50 mg twice daily.
Must be requested by a neurooncologist or a pediatrician with expertise in neurooncology.

9901-0479

Current Body Surface Area (BSA): _____ m²

SECTION 4 – CURRENT PLEXIFORM NEUROFIBROMAS (PN) CLINICAL INFORMATION

Information below must be gathered within the 3 month period immediately preceding this request.

Parameter	**Finding - Date of Collection (YYYY/MM): _____**
Impairment of physical function, impairment of organ function, or impairment of the nervous system **(required)** • Please provide a narrative description and/or provide copies of applicable formal tests/scales (e.g., PROMIS scale, 6-minute walk test, PFTs, dysfunctional voiding questionnaire, HOTV eye chart test, etc.)	
Impact on quality of life **(required)** • Please provide a narrative description and/or provide copies of a formal scale (e.g., PedsQL scale, etc.)	
Other clinical signs/symptoms of disease (e.g., tumour size/volume, PN related pain score, etc.) **(required)** • Please specify the parameter being assessed and include a narrative description and/or provide copies of a formal test/scale, if applicable.	
Other	

Please note: The same parameters provided above will be required on all future renewal request(s) to demonstrate clinical improvement or stabilization. Additional room for comments is available in Section 7, if needed.

Please complete additional information on page 2 >>

Patient (Family) Name	Patient (Given) Name(s)	Personal Health Number (PHN)

SECTION 5 – INITIAL COVERAGE CRITERIA: 18 MONTHS

Approval subject to patient having met ALL of the criteria below (mark boxes and complete blanks as applicable):

- ☐ Patient has a diagnosis of neurofibromatosis type 1 and is aged 2 to under 18 years.
- ☐ Patient has symptomatic PN, as demonstrated in Section 4.
- ☐ Patient has inoperable PN (could not be completely surgically removed without risk of substantial morbidity due to encasement of, or close proximity to, vital structures, or invasiveness, or high vascularity of the PN).
  Please provide the factors related to the PN that make it inoperable:

SECTION 6 – RENEWAL COVERAGE CRITERIA: 12 MONTHS

Approval subject to patient having met ALL of the criteria below (mark boxes and complete blanks as applicable):

- ☐ The patient has had clinical improvement or stabilization after the initiation of selumetinib, as evidenced by current information provided in Section 4.

NOTES:
Selumetinib must be discontinued upon occurrence of disease progression (e.g., tumour growth, increased pain, worsening functioning, worsening quality of life, or worsening of symptoms, etc.)

SECTION 7 – ADDITIONAL OPTIONAL COMMENTS

SECTION 8 – NEUROONCOLOGIST OR PEDIATRICIAN'S SIGNATURE

Personal information on this form is collected under the authority of, and in accordance with, the *British Columbia Pharmaceutical Services Act* 22(1) and *Freedom of Information and Protection of Privacy Act* 26 (a),(c),(e). The information is being collected for the purposes of (a) administering the PharmaCare program, (b) analyzing, planning and evaluating the Special Authority and other Ministry programs and (c) to manage and plan for the health system generally. If you have any questions about the collection of this information, call Health Insurance BC from Vancouver at 1-604-683-7151 or from elsewhere in BC toll free at 1-800-663-7100 and ask to consult a pharmacist concerning the Special Authority process.

I have discussed with the patient that the purpose of releasing their information to PharmaCare is to obtain Special Authority for prescription coverage and for the purposes set out here.

Neurooncologist/Pediatrician's Signature (Mandatory)

PharmaCare may request additional documentation to support this Special Authority request. Actual reimbursement is subject to the rules of a patient's PharmaCare plan, including any annual deductible requirement, and to any other applicable PharmaCare pricing policy.

Report all adverse events to the post-market surveillance program, Canadian Vigilance, toll-free 1-866-234-2345 (health professionals only).

PHARMACARE USE ONLY

STATUS	EFFECTIVE DATE (YYYY / MM / DD)	DURATION OF APPROVAL

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