Prescriber Criteria Form

Fruzaqla 2025 PA Fax 6255-A v1 010125.docx
Fruzaqla (fruquintinib)
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 Fruzaqla (fruquintinib).

Drug Name:
Fruzaqla (fruquintinib)

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 metastatic colorectal cancer? [If no, then no further questions.]	Yes ◯	No ◯
2	Has the patient previously been treated with BOTH of the following: A) fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, B) anti-vascular endothelial growth factor (VEGF) therapy? [If no, then no further questions.]	Yes ◯	No ◯
3	Is the disease RAS wild-type? [If no, then no further questions.]	Yes ◯	No ◯
4	Does the patient meet ONE of the following: A) previously treated with anti-epidermal growth factor receptor (EGFR) therapy, B) not medically appropriate to treat with anti-EGFR therapy?	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:_____