Prescriber Criteria Form

Lonsurf 2025 PA Fax 1298-A v1 010125.docx
Lonsurf (trifluridine and tipiracil)
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 Lonsurf (trifluridine and tipiracil).

Drug Name:
Lonsurf (trifluridine and tipiracil)

| **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 colorectal cancer (including appendiceal adenocarcinoma)?<br>[If no, then skip to question 3.] | Yes | No |
| 2 | Is the disease advanced or metastatic?<br>[No further questions.] | Yes | No |
| 3 | Does the patient have a diagnosis of gastric, esophageal, or gastroesophageal junction adenocarcinoma?<br>[If no, then no further questions.] | Yes | No |
| 4 | Has the patient been previously treated with at least two prior lines of chemotherapy?<br>[If no, then no further questions.] | Yes | No |
| 5 | Is the disease unresectable locally advanced, recurrent, or metastatic? | 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:____________________**