Prescriber Criteria Form Lonsurf 2024 PA Fax 1298-A v1 010124.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)? [If no, then skip to question 3.]	Yes	No
2	Is the disease advanced or metastatic? [No further questions.]	Yes	No
3	Does the patient have a diagnosis of gastric or gastroesophageal junction adenocarcinoma? [If no, then no further questions.]	Yes	No
4	Has the patient been previously treated with at least two prior lines of chemotherapy? [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:_____