

Lonsurf® (Trifluridine/Tipiracil) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information

Pharmacy billing (NDC: _____) Start Date (or date of next dose): _____

Dose: _____ Dosing Regimen: _____

Billing Provider Information

Pharmacy NPI: _____ Pharmacy Name: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information:

Colorectal Cancer

- A. Is the diagnosis metastatic, recurrent, or unresectable? Yes ___ No ___
- B. Was the member previously treated with a fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy? Yes ___ No ___
- C. Was the member previously treated with an anti-vascular endothelial growth factor (VEGF) therapy? Yes ___ No ___
- D. Is disease RAS wild-type disease? Yes ___ No ___
 - i. If yes, was the member previously treated with an anti-epidermal growth factor receptor (EGFR) therapy? Yes ___ No ___
- E. Will Lonsurf® be used as monotherapy or in combination with bevacizumab? Yes ___ No ___

Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma

- A. Was the member previously treated with at least 2 prior lines of chemotherapy that included a fluoropyrimidine, a platinum, paclitaxel, docetaxel, or irinotecan? Yes ___ No ___
- B. Is disease human epidermal receptor type 2 (HER2) positive? Yes ___ No ___
 - i. If yes, did prior treatment include HER2 targeted therapy? Yes ___ No ___

If diagnosis is not listed above, please indicate diagnosis: _____

For Continued Authorization:

1. Date of last dose: _____
 2. Does the member have any evidence of progressive disease while on Lonsurf®? Yes ___ No ___
 3. Has the member experienced any adverse drug reactions related to Lonsurf® therapy? Yes ___ No ___
- If yes, please specify adverse reactions: _____

Prescriber Signature: _____ Date: _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Failure to complete this form in full will result in processing delays.

<p>Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.</p>	<p style="text-align: center;"><u>CONFIDENTIALITY NOTICE</u></p> <p><i>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.</i></p>
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