Fruzaqla (fruquintinib)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL**		**IF RENEWAL:** DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

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Revision Date: 5.1.2024

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Metastatic colorectal cancer(mCRC) ☐ Other diagnosis: _____ ICD-10 Code(s):	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is patient going to be using drug in a clinical trial? ☐ Yes ☐ No

Did patient progress on or was intolerant to treatment with either Lonsurf(trifluridine/tipiracil) or Stivarga(regorafenib) or both? ☐ Yes ☐ No Please submit documentation.

Has patient been previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy? ☐ Yes ☐ No Please submit documentation.

Has patient been previously treated with an anti-VEGF therapy? ☐ Yes ☐ No Please submit documentation.

Is patient's tumor RAS wild-type? ☐ Yes ☐ No Please submit documentation.

If patient's tumor is RAS wild-type, and medically appropriate, was patient treated with an anti-EGFR therapy? ☐ Yes ☐ No Please submit documentation.

Does patient have microsatellite-high (MSI-H) or mismatch repair deficient (dMMR) tumors? ☐ Yes ☐ No Please submit documentation.

If patient has microsatellite-high (MSI-H) or mismatch repair deficient (dMMR) tumors, was patient treated with immune checkpoint inhibitors? ☐ Yes ☐ No Please submit documentation.

Was patient ineligible for treatment with a checkpoint inhibitor? ☐ Yes ☐ No Please submit documentation.

Does patient have an Eastern Cooperative Oncology Group (ECOG) performance status of 0-1?

Does patient have BRAF-mutant tumors? ☐ Yes ☐ No Please submit documentation.

If patient has a BRAF-mutant tumor, was patient treated with a BRAF inhibitor? ☐ Yes ☐ No Please submit documentation.

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Was the patient ineligible for treatment with a BRAF inhibitor? □ Yes □ No Please submit documentation.
Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909