Lonsurf (trifluridine; tipiracil)
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** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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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 ☐ Gastric adenocarcinoma ☐ Adenocarcinoma of the GE junction ☐ Other diagnosis: _____ICD-10: _____	

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

Clinical Information:

For diagnosis of metastatic colorectal cancer, answer the following:

Will patient use Lonsurf(trifluridine/tipiracil) as monotherapy? ☐ Yes ☐ No

Will patient use Lonsurf(trifluridine/tipiracil) in combination with Avastin(bevacizumab)? ☐ Yes ☐ No

Does the patient have an ECOG performance score of 0 or 1?* ☐ Yes ☐ No
Please submit documentation.

Select if the patient has received at least two prior regimens of standard chemotherapies that cumulatively included all of the following:
- ☐ **Fluoropyrimidine (e.g., 5-FU, floxuridine or capecitabine)**
- ☐ **Oxaliplatin (Eloxatin)**
- ☐ **Irinotecan (Camptosar)**
- ☐ **Bevacizumab (Avastin)**

Has the patient's tumor progressed within 3 months after the last administration of chemotherapy?* ☐ Yes ☐ No
Please provide chart documentation.

Has the patient had a clinically significant adverse event from standard chemotherapies that precluded re-administration of those therapies?* ☐ Yes ☐ No *Please provide chart documentation*

Is the patient's tumor KRAS wild type?* ☐ Yes ☐ No *Please submit documentation.*

Has the patient received a previous chemotherapy regimen that includes use of cetuximab (Erbitux) or panitumumab (Vectibix)? ☐ Yes ☐ No

Does the prescribed dose EXCEED 160 mg daily for a total of 10 days of treatment per 28 day treatment cycle?
☐ Yes ☐ No

For diagnosis of gastric adenocarcinoma or adenocarcinoma of the GE junction:
Has the patient has received at least 2 prior treatment regimens? ☐ Yes ☐ No *Please submit chart documentation*

Revision Date: 6/15/2023

Prime THERAPEUTICS™

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Did the patient's prior regimen(s) include a fluoropyrimidine? □ **Yes** □ **No** ***Please submit chart documentation***

Did the patient's prior regimen(s) include a platinum-based therapy? □ **Yes** □ **No** ***Please submit chart documentation.***

Did the patient's prior regimen(s) include either a taxane-containing regimen and/or an irinotecan-containing regimen? □ **Yes** □ **No** ***Please submit chart documentation.***

Has the patient 's tumor progressed within 3 months of the last prior regimen? □ **Yes** □ **No** ***Please submit chart documentation.***

Is the patient's tumor HER2-POSITIVE? □ **Yes** □ **No** ***Please submit chart documentation.***

If tumor is HER2-positive, did patient receive HER2/neu-targeted therapy? □ **Yes** □ **No** ***Please submit chart 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

Revision Date: 6/15/2023

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