



**Lonsurf (Trifluridine; Tipiracil)  
Prior Authorization Request Form**

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



**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: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI\\_DISCLOSURE\\_AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

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MEMBER'S LAST NAME: \_\_\_\_\_ MEMBER'S FIRST NAME: \_\_\_\_\_

<b>1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?</b> <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
<b>MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):</b>  	<b>DURATION OF THERAPY (SPECIFY DATES):</b>  	<b>RESPONSE/REASON FOR FAILURE/ALLERGY:</b>  
<b>2. LIST DIAGNOSES:</b> <input type="checkbox"/> Metastatic colorectal cancer <input type="checkbox"/> Gastric adenocarcinoma <input type="checkbox"/> Adenocarcinoma of the GE junction <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____		<b>ICD-10:</b>  
<b>3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.</b>		
<b>Clinical Information:</b> <b>For diagnosis of metastatic colorectal cancer, answer the following:</b> <b>Does the patient have an ECOG performance score of 0 or 1?*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please submit documentation.</i>  <b>Select if the patient has received at least two prior regimens of standard chemotherapies that cumulatively included all of the following:</b> <input type="checkbox"/> Fluoropyrimidine (e.g., 5-FU, floxuridine or capecitabine) <input type="checkbox"/> Oxaliplatin (Eloxatin) <input type="checkbox"/> Irinotecan (Camptosar) <input type="checkbox"/> Bevacizumab (Avastin)  <b>Has the patient's tumor progressed within 3 months after the last administration of chemotherapy?*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please provide chart documentation.</i>  <b>Has the patient had a clinically significant adverse event from standard chemotherapies that precluded re-administration of those therapies?*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please provide chart documentation</i>  <b>Is the patient's tumor KRAS wild type?*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please submit documentation.</i>  <b>Has the patient received a previous chemotherapy regimen that includes use of cetuximab (Erbix) or panitumumab (Vectibix)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Does the prescribed dose EXCEED 160 mg daily for a total of 10 days of treatment per 28 day treatment cycle?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>For diagnosis of gastric adenocarcinoma or adenocarcinoma of the GE junction:</b> <b>Has the patient has received at least 2 prior treatment regimens?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please submit chart documentation</i>  <b>Did the patient's prior regimen(s) include a fluoropyrimidine?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please submit chart documentation</i>		





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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:** \_\_\_\_\_

**CONFIDENTIALITY NOTICE:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**FAX THIS FORM TO: 800-424-7640**

**MAIL REQUESTS TO:** Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.  
4801 E. Washington Street, Phoenix, AZ 85034  
Phone: 877-228-7909

