OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
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.*

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*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.*