Please complete ALL information below and fax your request to 1-888-671-5285

Lonsurf® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Colorectal cancer
❑ Gastric cancer
❑ Gastroesophageal junction adenocarcinoma
❑ Other diagnosis: ______________________________________ ICD-10 Code(s): ______________________________

Prescriber's Specialty:

Is Lonsurf prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**

For colorectal cancer, answer the following:

Does the patient have metastatic colorectal cancer (mCRC)? ❑ **Yes** ❑ **No**

Select if the patient has had trial and failure, intolerance, or contraindication to the following:

❑ Fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy (e.g., FOLFOX, FOLFIRI, FOLFOXIRI)
❑ Anti-VEGF therapy (e.g., Avastin [bevacizumab], Zaltrap [ziv-aflibercept])
❑ Anti-EGFR therapy (e.g., Vectibix [panitumumab], Erbitux [cetuximab])

Select if the patient has one of the following:

❑ RAS mutant tumors
❑ RAS wild-type tumors

For gastric cancer or gastroesophageal junction adenocarcinoma, answer the following:

Select if the patient has had a trial and failure, contraindication or intolerance to the following:

❑ Fluoropyrimidine-based chemotherapy
❑ Her2/neu-targeted therapy (if appropriate)
❑ Platinum-based chemotherapy
❑ Taxane or irinotecan-based chemotherapy

For gastric cancer, does the patient have metastatic gastric cancer? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following:

Does the patient show evidence of progressive disease while on Lonsurf therapy? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

What is the quantity requested per MONTH? _________

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Office use only: Lonsurf_FSP_2019Jul-W

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What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: ____

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: This request may be denied unless all required information is received.

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