

Prescriber Criteria Form

Fruzaqla 2026 PA Fax 6255-A v1 010126.docx

Fruzaqla (fruquintinib)

Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.

Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Fruzaqla (fruquintinib).

Drug Name:
Fruzaqla (fruquintinib)

Patient Name:

Patient ID:

Patient DOB:

Patient Phone:

Prescriber Name:

Prescriber Address:

City:

State:

Zip:

Prescriber Phone:

Prescriber Fax:

Diagnosis:

ICD Code(s):

Please circle the appropriate answer for each question.

1	Does the patient have a diagnosis of colorectal cancer (CRC), including appendiceal adenocarcinoma? [If no, then no further questions.]	Yes	No
2	Is the disease advanced or metastatic? [If no, then no further questions.]	Yes	No
3	Will the requested drug be used as a single agent? [If no, then no further questions.]	Yes	No
4	Will the requested drug be used as second line or subsequent therapy?	Yes	No

Comments: _____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:** _____