

Prescriber Criteria Form  
Lonsurf 2026 PA Fax 1298-A v1 010126.docx  
Lonsurf (trifluridine and tipiracil)  
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 Lonsurf (trifluridine and tipiracil).

Drug Name:  
Lonsurf (trifluridine and tipiracil)

<b>Patient Name:</b>		
<b>Patient ID:</b>		
<b>Patient DOB:</b>	<b>Patient Phone:</b>	
<b>Prescriber Name:</b>		
<b>Prescriber Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Prescriber Phone:</b>	<b>Prescriber Fax:</b>	
<b>Diagnosis:</b>	<b>ICD Code(s):</b>	

**Please circle the appropriate answer for each question.**

1	Does the patient have a diagnosis of colorectal cancer (including appendiceal adenocarcinoma)? [If no, then skip to question 3.]	Yes	No
2	Is the disease advanced or metastatic? [No further questions.]	Yes	No
3	Does the patient have a diagnosis of gastric, esophageal, or gastroesophageal junction adenocarcinoma? [If no, then no further questions.]	Yes	No
4	Has the patient been previously treated with at least two prior lines of chemotherapy? [If no, then no further questions.]	Yes	No
5	Is the disease unresectable locally advanced, recurrent, or metastatic?	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:** \_\_\_\_\_