US Family Health Plan

Prior Authorization Request Form for

Fruquintinib (Fruzaqla)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization does not expire.

Step 1

Please complete patient and physician information (please print):

Patient Name: ______________________ Physician Name: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Sponsor ID #: ______________________ Phone #: ______________________

Date of Birth: Secure Fax #:

Step 2

Please complete the clinical assessment:

Question		
1. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication being prescribed by or consultation with a hematologist or oncologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. What is the diagnosis or indication?	☐ Metastatic colorectal cancer – proceed to question **4** ☐ Other – proceed to question **8**	
4. Has the patient had progression following treatment with fluoropyrimidine, oxaliplatin and irinotecan-based chemotherapy?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the patient had progression following anti-VEGF therapy (for example, bevacizumab, Zaltrap, Cyramza)?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the tumor RAS wild-type?	☐ Yes Proceed to question **7**	☐ No Proceed to question **10**
7. Has the patient had progression following treatment with anti-EGFR therapy (for example, cetuximab, panitumumab)?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**

Question		
8. **Please provide the diagnosis.**	______________________ Proceed to question **9**	
9. **Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?**	☐ Yes Proceed to question **10**	☐ No **STOP Coverage not approved**
10. **Is the provider aware of all monitoring requirements and screening precautions?**	☐ Yes **Sign and date below**	☐ No **STOP Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

______________________ Prescriber Signature

__________ Date