

**Applicable Drugs:** Fruzaqla (fruquintinib)

**Preferred:** N/A

**Non-preferred:** N/A

**Date of Origin:** 9/30/2024

**Date Last Reviewed / Revised:** 8/28/2026

## **PRIOR AUTHORIZATION CRITERIA**

(May be considered medically necessary when criteria I through V are met)

- I. Documentation of the following FDA-approved diagnosis and must meet all criteria listed under the applicable diagnosis:

FDA-Approved Indication(s)

A. Metastatic or advanced colorectal cancer (mCRC)

- i. Documented treatment failure, intolerance, or contraindication to all the following:

1. Fluoropyrimidine-based chemotherapy
2. Oxaliplatin-based chemotherapy
3. Irinotecan-based chemotherapy
4. Anti-vascular endothelial growth factor (VEGF) therapy

- ii. Documentation of RAS mutation status

1. If tumor is RAS wild type, criteria a or b is met:

- a. Documentation of a trial of anti-epidermal growth factor receptor (EGFR) therapy.
- b. Documentation by prescriber that anti-epidermal growth factor receptor (EGFR) therapy is not medically appropriate.

~~e-iii.~~ Fruzaqla (fruquintinib) will be used as a single agent for subsequent therapy.

Other Uses With Supportive Evidence

B. Appendiceal adenocarcinoma

- II. Minimum age requirement: 18 years old.
- III. Treatment must be prescribed by or in consultation with an oncologist or hematologist.
- IV. Request is for a medication with the appropriate FDA labeling, or its use is supported by current National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1 or 2A.

- V. Refer to the plan document for the list of preferred products. If the requested agent is not listed as a preferred product, must have documented treatment failure or contraindication to the preferred product(s).

#### EXCLUSION CRITERIA

- N/A

#### OTHER CRITERIA

- N/A

#### QUANTITY / DAYS SUPPLY RESTRICTIONS

- Fruzaqla (fruquintinib) 1 mg capsule: 84 capsules per 28 days
- Fruzaqla (fruquintinib) 5 mg capsule: 21 capsules per 28 days

#### APPROVAL LENGTH

- **Authorization:** 6 months
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and does not show evidence of progressive disease.

#### APPENDIX

N/A

#### REFERENCES

1. Fruzaqla. Prescribing information. Takeda Pharmaceuticals America, Inc: 2025. Accessed August 15, 2026. <https://www.fruzaqlahcp.com/sites/default/files/resources/fruzaqla-prescribing-information.pdf>
2. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. Colon Cancer. Version 2.2026. Updated April 7, 2026. Accessed August 15, 2026. [https://www.nccn.org/professionals/physician\\_gls/pdf/colon.pdf](https://www.nccn.org/professionals/physician_gls/pdf/colon.pdf)
3. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. Rectal Cancer. Version 2.2026. Updated April 7, 2026. Accessed August 15, 2026. [https://www.nccn.org/professionals/physician\\_gls/pdf/rectal.pdf](https://www.nccn.org/professionals/physician_gls/pdf/rectal.pdf)
4. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. Appendiceal Neoplasms and Cancers. Version 2.2026. Updated April 10, 2026. Accessed August 15, 2026. [https://www.nccn.org/professionals/physician\\_gls/pdf/appendiceal.pdf](https://www.nccn.org/professionals/physician_gls/pdf/appendiceal.pdf)

**DISCLAIMER:** Medication Policies are developed to help ensure safe, effective, and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgement in providing the most appropriate care for their patients.