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

# Xeloda® (capecitabine) Prior Authorization Request Form

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

| 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 | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

## Clinical Information (required)

**Select the diagnosis below:**

❑ Metastatic breast cancer
❑ Colon cancer
❑ Other: _____ ICD-10 code(s): _____

**For metastatic breast cancer, answer the following:**

Select the intent of therapy below:
- ❑ Monotherapy
- ❑ Used in combination with docetaxel

Has the patient failed prior anthracycline-containing therapy? ❑ **Yes** ❑ **No**

Select if the patient is resistant to the following therapies:
- ❑ An anthracycline-containing regimen (or for whom further anthracycline therapy is not indicated)
- ❑ Paclitaxel

Is the requested medication prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**

**For colon cancer, answer the following:**

Does the patient have a diagnosis of metastatic colorectal cancer? ❑ **Yes** ❑ **No**
Does the patient have a diagnosis of Duke's C colon cancer? ❑ **Yes** ❑ **No**
Has the patient undergone complete resection of the primary tumor? ❑ **Yes** ❑ **No**
Is the requested medication prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**

**Reauthorization:**

**If this is a reauthorization request, answer the following question:**

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

**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.