



Xeloda (capecitabine) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ MEMBER'S FIRST NAME: _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

URGENT

MEMBER INFORMATION		
LAST NAME:	FIRST NAME:	
PHONE NUMBER:	DATE OF BIRTH:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
PATIENT INSURANCE ID NUMBER:		

MALE FEMALE HEIGHT (IN/CM): _____ WEIGHT (LB/KG): _____ ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
 AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION		
LAST NAME:	FIRST NAME:	
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:	
NPI NUMBER:	DEA NUMBER:	
PHONE NUMBER:	FAX NUMBER:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY <input type="checkbox"/> RENEWAL		IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page





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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? YES (if yes, complete below) NO

MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:

2. LIST DIAGNOSES: **ICD-10:**

<input type="checkbox"/> Metastatic breast cancer <input type="checkbox"/> Breast cancer with residual disease <input type="checkbox"/> Metastatic colorectal cancer <input type="checkbox"/> Gastric cancer <input type="checkbox"/> Esophageal cancer <input type="checkbox"/> Gastro-esophageal cancer <input type="checkbox"/> Advanced Pancreatic cancer dx code 157.x, (excludes neuroendocrine tumors 209.x) <input type="checkbox"/> Gallbladder cancer <input type="checkbox"/> Adenocarcinoma of small intestine <input type="checkbox"/> Locally advanced non-metastatic bladder cancer <input type="checkbox"/> Recurrent or metastatic squamous cell head and neck cancer <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____	
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3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:
Will capecitabine(Xeloda) be used in conjunction with a clinical trial? Yes No

Is prescriber by an oncologist or hematologist? Yes No

Document the patient's body surface area (BSA): _____ m2

For Advanced pancreatic cancer, also answer the following:
Does the patient have advanced pancreatic cancer (excluding neuroendocrine cancer/tumors)? Yes No
Is Xeloda(capecitabine) being used as adjuvant therapy with radiation? Yes No
Is Xeloda(capecitabine) being used as monotherapy? Yes No
Is Xeloda(capecitabine) being used in combination with gemcitabine? Yes No
If patient using in combination with gemcitabine, also answer the following:
Has patient had a complete macroscopic resection(R0 or R1) for pancreatic ductal adenocarcinoma? Yes No
Please submit histology report.
Has tumor resection occurred within the last 12 weeks? Yes No
Has patient had a pancreatic R2 resection? Yes No
Does patient have TNM Stage IV pancreatic cancer? Yes No
Does patient have evidence of malignant ascites, liver or peritoneal metastasis or spread to other distant abdominal or extra-abdominal organs? Yes No
Has patient had prior neo-adjuvant chemotherapy for pancreatic cancer? Yes No





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For colorectal or small intestine cancers, also answer the following:

Is Xeloda(capecitabine) being used as adjuvant/neoadjuvant therapy with radiation? Yes No

For metastatic colorectal cancer, also answer the following:

Has patient been previously treated for metastatic colorectal cancer? Yes No Please submit documentation.

Has patient had six 3-week cycles of induction with CAPOX(capecitabine-oxaliplatin-bevacizumab) ? Yes No

If no to the above question, will patient need six 3-week cycles of induction with CAPOX(capecitabine-oxaliplatin-bevacizumab) ? Yes No

Will patient be using capecitabine in combination with bevacizumab as first-line treatment? Yes No

Will patient be using capecitabine in combination with bevacizumab as second or more lines of treatment? Yes No

Will patient be prescribed a maximum dose of 1250mg/m² twice daily on days 1-14 x 6 cycles when being used as second or more lines of treatment? Yes No

For locally advanced non-metastatic bladder cancer, also answer the following:

Is Xeloda(capecitabine) being used as adjuvant/neoadjuvant therapy with radiation? Yes No

For Breast Cancer, also answer the following:

Does patient have metastatic breast cancer? Yes No

Has patient had previous treatment with an anthracycline-based chemotherapy? Yes No Please submit documentation.

Will patient use capecitabine in combination with doxetaxel(Taxotere)? Yes No

Will patient use capecitabine as monotherapy? Yes No

Was patient resistant to both paclitaxel and an anthracycline-based regimen? Yes No Please submit documentation.

Does patient have HER2-negative or triple-negative breast cancer? Yes No

Does patient have residual disease after pre-operative therapy with taxane, alkylator, or anthracycline-based chemotherapy or combinations of those regimens? Yes No Please submit documentation.

Will patient be prescribed a maximum dose of 1250mg/m² twice daily on days 1-14 x 6 cycles? Yes No Please submit documentation.





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Recurrent or Metastatic Squamous Cell Head and Neck Cancer:

Does patient have a diagnosis of recurrent or metastatic head and neck squamous cell carcinoma? Yes No
Please submit documentation.

Has patient been previously treated with at least one platinum-based therapy regimen for their recurrent or metastatic head and neck squamous cell cancer? Yes No Please submit documentation.

Is patient considered ineligible for surgery and/or chemoradiotherapy? Yes No Please submit documentation.

Will Xeloda(capecitabine) will be used as monotherapy? 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: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

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FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program

Attn: CP – 4201

P.O. Box 64811

St. Paul, MN 55164-0811

