# Xeloda (Capecitabine)
## Prior Authorization Request Form

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

**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

**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:** |
| ☐ **NEW THERAPY** | ☐ **RENEWAL** | **IF RENEWAL:** DATE THERAPY INITIATED: | |
| DURATION OF THERAPY (SPECIFIC DATES): | | | |

*Continued on next page.*

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**MEMBER'S LAST NAME:** ___________________________ **MEMBER'S FIRST NAME:** ___________________________

| 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: |
|---|---|
| □ Duke's stage C colon cancer<br>□ Metastatic breast cancer<br>□ Metastatic colorectal cancer<br>□ Other diagnosis: ________________ICD-10_______________________ | |

**3. REQUIRED CLINICAL INFORMATION:** PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

**Clinical Information:**
**Was Xeloda (capecitabine) prescribed by an oncologist or hematologist?□ Yes □ No**

**Select if the patient has the following:**
- □ **Severe renal impairment, defined as a creatinine clearance less than 30 mL/minute**
- □ **Known dihydropyrimidine dehydrogenase (DPD) deficiency**

**Document the patient's body surface area (BSA): _______________m2**

**For Duke's C colon cancer, also answer the following:**
**Will Xeloda (capecitabine) be used as a single agent for the adjuvant treatment of Dukes' stage C colon cancer? □ Yes □ No**

**Has the patient undergone complete resection of the primary tumor?* □ Yes □ No**
***Please provide documentation.***

**Will Xeloda (capecitabine) be used as adjuvant/neo adjuvant therapy with radiation prior to FOLFOX (leucovorin, fluorouracil, and oxaliplatin) (or similar) treatment or prior to surgical resection? □ Yes □ No**

**For metastatic colorectal cancer, also answer the following:**
**Does the patient have metastatic colorectal cancer (excluding neuroendocrine cancer/tumors)? □ Yes □ No**

**For metastatic breast cancer, also answer the following:**
**Is Xeloda (capecitabine) being used in combination with docetaxel after failure of prior anthracycline-containing chemotherapy? □ Yes □ No**

**Is Xeloda (capecitabine) being used as monotherapy in patients that are resistant to both paclitaxel and an anthracycline-containing chemotherapy regimen or resistant to paclitaxel and for whom further anthracycline therapy is not indicated? □ Yes □ No**

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**Is Xeloda (capecitabine) being used in combination with trastuzumab (Herceptin) for HER-2 positive breast cancer after failure of taxanes and/or anthracyclines? □ Yes □ No**

**Is Xeloda (capecitabine) being used in combination therapy with Tykerb (lapatinib) for HER-2 positive (or HER-2 indeterminate) breast cancer with brain metastases after whole-brain radiotherapy and/or stereotactic radiosurgery (SBRT)? □ 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; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909

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