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

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

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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:**
☐ Metastatic breast cancer ☐ Breast cancer with residual disease ☐ Metastatic colorectal cancer ☐ Gastric cancer ☐ Esophageal cancer ☐ Gastro-esophageal cancer ☐ Advanced Pancreatic cancer dx code 157.x, (excludes neuroendocrine tumors 209.x) ☐ Gallbladder cancer ☐ Adenocarcinoma of small intestine ☐ Locally advanced non-metastatic bladder cancer ☐ Other diagnosis: _____ICD-10_____	

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 <u>Advanced pancreatic cancer,</u> 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

<u>If patient using in combination with gemcitabine, also answer the following:</u>

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 <u>colorectal or small intestine cancers</u>, also answer the following:
Is Xeloda(capecitabine) being used as adjuvant/neoadjuvant therapy with radiation? □ Yes □ No

For <u>metastatic colorectal cancer</u>, 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/m^2 twice daily on days 1-14 x 6 cycles when being used as second or more lines of treatment? □ Yes □ No

<u>For locally advanced non-metastatic bladder cancer</u>, also answer the following:
Is Xeloda(capecitabine) being used as adjuvant/neoadjuvant therapy with radiation? □ Yes □ No

<u>For Breast Cancer, also answer the following</u>:
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/m^2 twice daily on days 1-14 x 6 cycles? □ Yes □ No Please submit documentation.

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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:** _____

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

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