1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Xeloda® (capecitabine) Prior Authorization Request Form (Page 1 of 2)

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

Clinical Information (required)

Select the diagnosis below:

❑ Metastatic breast cancer
❑ Metastatic colorectal cancer
Other:_____ICD-10 code(s): _____

For 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 patient's creatinine clearance greater than or equal to 30 mL/minute? ❑ **Yes** ❑ **No**

For colon cancer, answer the following:

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 patient's creatinine clearance greater than or equal to 30 mL/minute? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following questions:

Does the patient show evidence of progressive disease while on Xeloda therapy? ❑ **Yes** ❑ **No**
Is the patient's creatinine clearance greater than or equal to 30 mL/minute? ❑ **Yes** ❑ **No**
Has the patient experienced severe mucocutaneous reactions (e.g., Stevens-Johnson Syndrome, Toxic Epidermal Necrolysis)? ❑ **Yes** ❑ **No**
Does the patient have a neutrophil count less than 1.5 x 10^9/L? ❑ **Yes** ❑ **No**
Does the patient have a thrombocyte count less than 100 x 10^9/L? ❑ **Yes** ❑ **No**

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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: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	