

PRIOR AUTHORIZATION REQUEST FORM EOC ID:

Xeloda (capecitabine)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name: Supervising Physician:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address: Address:			
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (if applicable)	:	
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or information following qu	n for this patient that may support a estions and sign.	pproval. Please answer the	
Q1. Please provide ICD code(s) for diagnosis			
Q2. What diagnosis is this drug being prescribed for?			
☐ Dukes' C colon cancer (proceed to Q4-5)			
☐ Metastatic colorectal cancer (proceed to Q4)			
☐ Metastatic breast cancer (proceed to Q4,6-9) ☐ Other			
Q3. If you selected "other" in question 2, please provide higher recommendation per NCCN compendia or guide		tent with a category 2A or	
Q4. Is the prescribing physician an Oncologist or Hematole	ogist?		
☐ Yes ☐ No			
Q5. If diagnosis is Dukes' C colon cancer, will Xeloda (capecitabine) be used as adjuvant therapy in a patient that has undergone complete resection of the primary tumor?			
☐ Yes ☐ No			



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Q6. If diagnosis is metastatic breast cancer, please indicat monotherapy?	e if Xeloda (capecitabine) will be used in combination or as
☐ Combination with docetaxel ☐ Monotherapy	
Q7. If diagnosis is metastatic breast cancer, has the patien containing therapy?	t failed or was the patient resistant to prior anthracycline-
☐ Yes ☐ No	
Q8. If diagnosis is metastatic breast cancer, is the patient a	a candidate for further anthracycline therapy?
☐ Yes ☐ No	
Q9. If diagnosis is metastatic breast cancer, is the patient I	resistant to paclitaxel?
☐ Yes ☐ No	
Q10. Additional Comments	
Prescriber Signature	Date
□ Expedited/Urgent - By checking this box and signing abov	va. I cartify that applying the standard review timeframe may

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function



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