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 for this patient that may support approval. Please answer the following questions and sign.

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 documentation that use is consistent with a category 1 or higher recommendation per NCCN compendia or guidelines.

Q4. Is the prescribing physician an Oncologist or Hematologist?

☐ 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

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:**

Q6. If diagnosis is metastatic breast cancer, please indicate if Xeloda (capecitabine) will be used in combination or as monotherapy?

☐ Combination with docetaxel
☐ Monotherapy

Q7. If diagnosis is metastatic breast cancer, has the patient failed or was the patient resistant to prior anthracycline-containing therapy?

☐ Yes ☐ No

Q8. If diagnosis is metastatic breast cancer, is the patient a candidate for further anthracycline therapy?

☐ Yes ☐ No

Q9. If diagnosis is metastatic breast cancer, is the patient resistant to paclitaxel?

☐ Yes ☐ No

Q10. Additional Comments

Prescriber Signature _____ Date _____

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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.**

	Prescriber Name:
Patient Name:	**Supervising Physician:**