



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations. Visit [go.covermymeds.com/OptumRx](http://go.covermymeds.com/OptumRx) to begin using this free service. Please note: All information below is required to process this request. Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

## Xeloda® (capecitabine) Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
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 <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information <small>(required)</small>					
<b>Select the diagnosis below:</b> <input type="checkbox"/> Metastatic breast cancer <input type="checkbox"/> Colon cancer <input type="checkbox"/> Other: _____ ICD-10 code(s): _____					
<b>For metastatic breast cancer, answer the following:</b> Select the intent of therapy below: <input type="checkbox"/> Monotherapy <input type="checkbox"/> Used in combination with docetaxel Has the patient failed prior anthracycline-containing therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Select if the patient is resistant to the following therapies: <input type="checkbox"/> An anthracycline-containing regimen (or for whom further anthracycline therapy is not indicated) <input type="checkbox"/> Paclitaxel Is the requested medication prescribed by or in consultation with an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>For colon cancer, answer the following:</b> Does the patient have a diagnosis of metastatic colorectal cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have a diagnosis of Duke's C colon cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient undergone complete resection of the primary tumor? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the requested medication prescribed by or in consultation with an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Reauthorization:</b> <b>If this is a reauthorization request, answer the following question:</b> Does the patient show evidence of progressive disease while on Xeloda therapy? <input type="checkbox"/> Yes <input type="checkbox"/> 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?

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Please note: This request may be denied unless all required information is received. For urgent or expedited requests please call 1-800-711-4555. This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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