



Send completed form to:  
 Peach State Health Plan Pharmacy Department  
 Fax: 1-866-374-1579

## Xeloda

### Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copay or medication delivery; please contact Peach State Health Plan at 1-800-514-0083 option # 2.

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_  
**Physician Office Address:** \_\_\_\_\_

1. What drug is being prescribed?  Xeloda  Other \_\_\_\_\_
2. What is the diagnosis?  
 Colon cancer  Breast cancer  
 Rectal cancer  Other \_\_\_\_\_
3. **What is the ICD9?** \_\_\_\_\_
4. Does the patient have a known dihydropyrimidine dehydrogenase (DPD) deficiency?  Yes  No
5. Does the patient have severe renal impairment (CrCl less than 30 mL/min)?  Yes  No
6. Is the patient receiving anticoagulation with a coumarin derivative?  
 Yes  No *\*If no, skip to Diagnosis Section.*
7. Will the patient be closely monitored (INR or PT) with appropriate dose adjustment for anticoagulant response?  Yes  No

*Complete the Section below designated for the patient's diagnosis*

#### SECTION A: Diagnosis Colon cancer OR Rectal cancer

8. In what clinical setting is Xeloda being used?  
 Neoadjuvant (before surgery)  For unresectable disease  
 Adjuvant (after surgery)  Other \_\_\_\_\_
9. What regimen will be used?  
 Capecitabine and oxaliplatin (CapeOX)  
 Xeloda monotherapy  
 Other \_\_\_\_\_
10. Does the patient have metastases?  Yes  No
11. If yes, are the metastases metachronous?  Yes  No

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Patient Name: \_\_\_\_\_ Patients Date of Birth: \_\_\_\_\_  
Patients ID : \_\_\_\_\_

12. Did the patient receive neoadjuvant chemoradiation?  Yes  No  
13. Will Xeloda be used before and after concurrent chemoradiation?  Yes  No  
14. Does the patient have advanced/metastatic disease or is the patient medically inoperable?  
 Yes  No  
15. Will Xeloda be used as initial chemotherapy?  Yes  No  
16. Will Xeloda be used after disease progression?  Yes  No

**SECTION B: Diagnosis Breast Cancer:**

17. Is the disease recurrent or metastatic?  Yes  No  
18. What therapy will be used with Xeloda?  
 Ixabepilone (i.e. Ixempra)  Trastuzumab (i.e. Herceptin)  
 Lapatinib (i.e. Tykerb)  None (Xeloda used as Monotherapy)  
 Docetaxel (i.e. Taxotere)  
19. Did the patient try and fail or become resistant to taxane therapy?  Yes  No  
20. Did the patient fail anthracycline therapy?  Yes  No  
21. Is anthracycline therapy contraindicated?  Yes  No  
22. What is HER2 status?  Positive  Negative  
23. What therapies has the patient been tried previously?  
 Anthracycline, taxane, and trastuzumab  
 Trastuzumab  
 Other \_\_\_\_\_  
24. The breast cancer hormone receptor is:  Positive  Negative  
25. Is the patient refractory to endocrine therapy?  Yes  No  
26. Is the breast cancer resistant to paclitaxel?  Yes  No  
27. Is the patient resistant to anthracycline-based chemotherapy or is it not indicated?  Yes  No  
28. Does the patient have visceral crisis?  Yes  No  
29. Is therapy requested for progressive disease?  Yes  No

**\*\*NOTE: We can NOT make a decision without documentation - Thank You\*\***

*Information given on this form is accurate as of this date:*

X \_\_\_\_\_

Prescriber or Authorized Signature

Date (mm/dd/yy)

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