XELODA

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.
Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES **PHONE 800-979-UPMC (8762)** **FAX 412-454-7722**

PLEASE TYPE OR PRINT NEATLY. *Incomplete responses may delay this request.*

Office Contact:	**Provider Specialty:**
Provider First Name:	**Provider Last Name:**
Provider Phone:	**Provider Fax:**

Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient Age:**	**Patient DOB:**

Drug Requested: ❑ Brand ❑ Generic	**Strength:**	**Frequency:**	**Expected length of therapy:**

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

❑ New medication ❑ Ongoing medication	**If ongoing, provide date started:**	**If medication is ongoing, Did member Show improvement while on therapy?**	**❑Yes ❑No**

Please indicate place of administration:	❑Physician Office ❑Hospital/Facility	**Please indicate how medication will be billed:**
Please provide facility/provider name and address:		**❑ Billed directly by the provider via JCODE Provide JCODE:________________ ❑ Billed by a pharmacy and delivered to the provider ❑ Billed by a pharmacy and delivered to the patient**

Please provide pertinent progress notes and lab/radiology reports that describe the member's current disease status.
☐ Chart documentation enclosed **☐ Chart documentation not available**

Please indicate the diagnosis and answer the corresponding questions:

Diagnosis	Question	Response
❑ Colon Cancer	Did the member have a resection (surgery)?	❑Yes ❑No
	If yes, please provide date of surgery:________________	
❑ Colorectal Cancer	Disease status:	❑ Advanced ❑ Metastatic ❑ Unresectable
	Please indicate stage:	
	Is Xeloda being used in combination with oxaliplatin (Eloxatin)?	❑Yes ❑No
❑ Breast Cancer	Please indicate disease status:	❑ Advanced ❑ Metastatic
	Please indicate stage:	
	Is cancer associated with HER2 over-expression?	❑Yes ❑No
	Is Xeloda being used as monotherapy?	❑Yes ❑No
	Is Xeloda being used in combination with docetaxel (Taxotere)?	❑Yes ❑No
	Is Xeloda being used in combination with lapatinib (Tykerb)?	❑Yes ❑No
	Has the member previously tried and failed a taxane such as paclitaxel (Taxol)?	❑Yes ❑No
	Has the member previously tried and failed an anthracycline such as Adriamycin (doxorubicin)?	❑Yes ❑No
	Has the member previously tried trastuzumab (Herceptin)?	❑Yes ❑No
	If yes, please list below:	

Medication Name	**Strength/Frequency**	**Dates of Therapy**	**Reason for Discontinuation**

Diagnosis	Question	Response
❑ Gastric Cancer	Please indicate disease status:	❑ Advanced ❑ Metastatic
	Please indicate stage:	
❑ Renal Cell Carcinoma	Please indicate disease status:	❑ Metastatic
	Please indicate stage:	
❑ Pancreatic Cancer	Please indicate disease status:	❑ Locally advanced ❑ Metastatic ❑ Unresectable
	Is Xeloda being used as monotherapy?	❑Yes ❑No
	Is Xeloda being used in combination with gemcitabine (Gemzar)?	❑Yes ❑No

Please be sure to complete and include the 2nd page of this form

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Patient Name	Patient UPMC Health Plan ID Number:	Patient DOB:

Please be sure to complete and include this page with the 1st page of this form

❑ Ovarian Cancer	Has the member been previously treated with taxanes and platinum?	❑Yes ❑No	If yes, please list below:

Medication Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuation

❑ Other Diagnosis, please list:	Please provide clinical literature/studies to support request for off-label use. ☐ Clinical literature/studies enclosed ☐ Clinical literature/studies not available

Is Xeloda being used in combination with any other therapies?	❑Yes ❑No If yes, please list below.

Medication Name	Strength/Frequency	Dates of Therapy

Please list below any other previous therapies tried:

Medication Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuation

Please provide any additional information which should be considered in the space below: