District of Columbia Pharmacy Program

Xeloda (Capecitabine) Breast Cancer

Request for Rx Prior Authorization

REQUEST DATE: / /

PATIENT INFORMATION

PATIENTS MEDICAID I D NUMBER

PATIENTS DATE OF BI RTH / /

PATIENTS FULL NAME

PRESCRIBER INFORMATION

PRESCRIBERS FULL NA ME

PRESCRIBER PHONE NUMBER: – –

PRESCRIBER FAX NUMBER: – –

PRESCRIBER DEA #: –

PRESCRIBER NPI #: –

THIS FORM IS FOR TREATING BREAST CANCER ONLY. DO NOT COMPLETE THIS FOR ANY OTHER CANCERS USE THE GENERAL PA FORM.

1. **What Stage of Breast Cancer?** _____
2. **What is the Estrogen Receptor Status?** _____ **+** _____ **-**
3. **Was there any prior neoplasm drug therapy?** _____
4. **Is there any concurrent combination therapy?** ☐ Yes ☐ No
   If yes, what? _____
5. **Is the patient on warfarin therapy??** ☐ Yes ☐ No
   ***If yes, what is the INR, and is this being monitor and by whom?** _____
6. **What is the patient CrCl (Creatinine Clearance)?** _____
   ***(MUST USE COCKCROFT-GAULT FORMULA):**
   [(140-Age) * Mass (in kg)] \ [72 * Serum creatinine (in mg/dL)]
   If the patient is female, multiply the above by 0.85
7. **Requested Dose:** _____ **Quantity** _____
8. **Direction** _____
9. **Total expected length of treatment duration including number of cycles prior to next Staging:** _____
10. **Cycle Length:** _____
11. **Date of next Staging:** _____

This form is to be used by the provider to obtain coverage for the drug listed above, which requires prior authorization. If you disagree with the final determination of this request, you are entitled to a hearing. To request a hearing, visit or write to the Office Administrator Hearings, 441 4th St., NW, Washington, DC 20001.

I certify that, to the best of my knowledge, all information I have provided on this request is complete and factual.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

FAX TO: District of Columbia Pharmacy Program
Phone: 1-800-273-4962
Fax: 1-866-535-7622

 Revision Date: 10/12/2015