CVS CAREMARK

Fax Referral To: 800-323-2445

Phone: 866-278-6634

Xeloda® (capecitabine)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Contact Phone: _____

INSURANCE INFORMATION *(If available, please copy and attach the front and back of insurance and prescription drug card)*

Primary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI**

Secondary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 code): ☐ 174.9 Neoplasm, Breast (Connective & Glandular Tissue) (Female) (Soft Parts) • Date of Diagnosis: _____

☐ Other: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

Xeloda may be approved for the following approved Food and Drug Administration (FDA) labeled indications:

- Patient presents with a diagnosis of Dukes' C Colon Cancer (**Colon Cancer**); ☐ Yes ☐ No **AND**
- Patient has undergone complete resection of the primary tumor when treatment with fluoropyrimidine therapy alone is preferred ☐ Yes ☐ No
- Patient presents with a diagnosis of Metastatic Colorectal Carcinoma (**Colon Cancer OR Rectal Cancer**); ☐ Yes ☐ No
- Patient presents with a diagnosis of advanced/metastatic gastric cancer ☐ Yes ☐ No
- Patient presents with a diagnosis of Metastatic Breast Cancer (**Breast Cancer**) ☐ Yes ☐ No
- The patient is using Xeloda as a first line therapy ☐ Yes ☐ No
- The patient is using Xeloda as a monotherapy ☐ Yes ☐ No
- The patient is using Xeloda as combination with docetaxol (Taxotere) or ixabepilone (Ixempra); ☐ Yes ☐ No
- The patient has failed (disease progression or intolerance to) therapy with other chemotherapy regimens; ☐ Yes ☐ No
- The patient has failed (disease progression or intolerance to) both paclitaxel (Taxol) and other chemotherapy regimens ☐ Yes ☐ No
- Patient is using Xeloda in combination with Tykerb ☐ Yes ☐ No
- Cancer has been confirmed HER2 positive ☐ Yes ☐ No
- Patient has had prior therapy with the following: ☐ Yes ☐ No
  - Herceptin® (trastuzumab) ☐ Yes ☐ No
  - A taxane (e.g., Paclitaxel, Abraxane™, Onxol®, Taxol®, Docetaxel, Taxotere®); ☐ Yes ☐ No
  - An anthracycline (e.g., Doxorubicin, Adriamycin®, Doxil®, Epirubicin, Ellence®) ☐ Yes ☐ No

Note: The following compendia, American Hospital Formulary Service, U.S. Pharmacopeia Dispensing Information, National Comprehensive Cancer Network NCCN), and Drug & Biologics Compendium™ Category of Evidence and Consensus are considered during prior authorization review if the drug is being prescribed for a condition not listed above. Additional information may be requested if documentation in the compendia is lacking.

Medical Necessity (please attach all supporting documentation):

PRESCRIPTION INFORMATION

MEDICATION	STENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Xeloda® (capecitabine)	☐ *2000mg/m² in two divided doses*: Take _____mg po BID (____500mg and ____150mg tablets) on days 1-14 of a 21-day cycle ☐ This patient will also be co-administering Tykerb® (lapatinib).		_____ 500mg tabs _____ 150mg tabs	
	☐ *2500mg/m² in two divided doses*: Take _____mg po BID (____500mg and ____150mg tablets) on days 1-14 of a 21-day cycle			
	☐ Other: _____			

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)