Draft

District of Columbia Pharmacy Program
Xeloda (Capecitabine) Breast Cancer
Request for Rx Prior Authorization

Request Date ☐☐ / ☐☐ / ☐☐☐☐

PATIENT INFORMATION

Patient's Medicaid ID Number ☐☐☐☐☐☐☐☐☐☐☐☐

Patient's Date of Birth ☐☐ / ☐☐ / ☐☐☐☐

Patient's Full Name

PRESCRIBER INFORMATION

Prescriber's Full Name

Prescriber Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Prescriber Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐

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:** _____

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

Signature of Prescriber_____ **Date** ☐☐ / ☐☐ / ☐☐☐☐

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

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