Xeloda® (capecitabine) Oral Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: ____________________ Phone: __________ Fax: __________

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:
Address:	City:	State: ZIP:
Home Phone: Work Phone:	Cell Phone:	Email:
Patient Current Weight: ______ lbs or ______ kgs Patient Height: _____ inches or ______ cms		Allergies:

B. INSURANCE INFORMATION

Aetna Member ID #: ____________	Does patient have other coverage? ☐ Yes ☐ No
Group #: ____________	If yes, provide ID#: __________ Carrier Name: __________
Insured:	Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: __________ **Medicaid:** ☐ Yes ☐ No If yes, provide ID #: __________

C. PRESCRIBER INFORMATION

First Name:		Last Name: (*Check one*): ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty (*Check one*): ☐ Oncologist ☐ Other: ____________

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: __________
Center Name: __________
☐ Home Infusion Center Phone: __________
Agency Name: __________
☐ Administration code(s) (CPT): __________
Address: __________

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: __________
Name: __________
Address: __________
Phone: __________ Fax: __________
TIN: __________ PIN: __________

E. PRODUCT INFORMATION

Request is for Medication: ☐ Xeloda **Dose:** __________ **Frequency:** __________
☐ *capecitabine* **Dose:** __________ **Frequency:** __________

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: ☐ __________ ☐ Other: __________ ** Please attach rationale*

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For All Xeloda Requests **(clinical documentation required):**

☐ Yes ☐ No Has the patient tried and failed to respond to an adequate trial of the generic equivalent capecitabine?
→ ☐ Yes ☐ No Does the patient have a documented contraindication, intolerance, or allergy to the generic equivalent capecitabine?
→ ***If yes***, please select: ☐ Contraindication ☐ Intolerance ☐ Allergy
→ Please provide the medication date range: ____/____/____ to ____/____/____

For ALL Requests **(clinical documentation required):**

Please indicate which diagnosis the patient is being treated for and answer subsequent questions:

☐ **Anal cancer**
☐ Yes ☐ No Will the drug be used in combination with mitomycin?

☐ **Breast cancer**
☐ Yes ☐ No Does the patient have recurrent or metastatic breast cancer? ☐ Recurrent ☐ Metastatic
☐ Yes ☐ No Does the patient have documented HER2 (-) breast cancer?
→ Will the drug be used alone or in combination with docetaxel? ☐ Alone ☐ In combination with docetaxel
☐ Yes ☐ No Does the patient have documented HER2 (+) breast cancer?
→ Will the drug be used in combination with Herceptin (trastuzumab) or Tykerb (lapatinib)? ☐ trastuzumab ☐ lapatinib
☐ Yes ☐ No Will the drug be used as adjuvant therapy?
→ ☐ Yes ☐ No Is this treatment for recurrent brain metastases in a patient with breast cancer?

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G. CLINICAL INFORMATION ***(continued)*** – Required clinical information must be completed in its entirety for all precertification requests.

☐ **Breast cancer**
Please select how treatment will be administered: ☐ As a single agent ☐ In combination with lapatinib (Tykerb) ☐ In combination with neratinib (Nerlynx) ☐ Other: ______

☐ **Cholangiocarcinoma**
Please specify: ☐ Extrahepatic ☐ Intrahepatic ☐ Other: ______
Is the patient's disease resectable, unresectable, or metastatic? ☐ Resectable ☐ Unresectable ☐ Metastatic ☐ Other: ______

☐ **Colon cancer**
Please select how treatment will be administered: ☐ As a single agent ☐ In combination with oxaliplatin
Will combination treatment with oxaliplatin be with or without Avastin (bevacizumab)? ☐ With bevacizumab ☐ Without bevacizumab

☐ **Esophageal cancer**

☐ **Esophagogastric junction cancer**

☐ **Fallopian tube cancer**
Please select which applies to the patient's disease: ☐ Persistent disease ☐ Recurrent disease ☐ Other: ______
Please select how the drug will be used: ☐ As adjuvant therapy ☐ Other: ______

☐ **Gallbladder cancer**
Does the patient have resectable, unresectable, or metastatic disease? ☐ Resectable ☐ Unresectable ☐ Metastatic ☐ Other: ______

☐ **Gastric cancer**

☐ **Head and neck cancer**
Does the patient have advanced, recurrent, or persistent disease? ☐ Advanced ☐ Recurrent ☐ Persistent ☐ Other: ______
☐ Yes ☐ No Will the drug be used as a single agent?

☐ **Neuroendocrine carcinoma and adrenal tumors**
☐ Yes ☐ No Will the drug be used for treatment of neuroendocrine carcinoma or adrenal tumor?
→ Please select: ☐ Neuroendocrine carcinoma ☐ Adrenal tumor
Please select the grade of the patient's tumor: ☐ Well-differentiated ☐ Moderately-differentiated ☐ Poorly-differentiated ☐ Undifferentiated ☐ Unknown
☐ Yes ☐ No Will the drug be used as primary treatment?
☐ Yes ☐ No Will the drug be used in combination with Temodar (temozolomide)?

☐ **Neuroendocrine tumors of the pancreas**
☐ Yes ☐ No Will the drug be used as a single agent?
☐ Yes ☐ No Will the drug be used in combination with Temodar (temozolomide)?

☐ **Occult primary carcinoma**
☐ Yes ☐ No Will the drug be used in combination with oxaliplatin?

☐ **Ovarian cancer**
Please select which applies to the patient's disease: ☐ Persistent disease ☐ Recurrent disease ☐ Other: ______
Please select how the drug will be used: ☐ As adjuvant therapy ☐ Other: ______

☐ **Pancreatic adenocarcinoma**

☐ **Penile cancer**
☐ Yes ☐ No Will the drug be used as palliative therapy?
☐ Yes ☐ No Will the drug be used as a single agent?

☐ **Primary peritoneal cancer**
Please select which applies to the patient's disease: ☐ Persistent disease ☐ Recurrent disease ☐ Other: ______
Please select how the drug will be used: ☐ As adjuvant therapy ☐ Other: ______

☐ **Rectal cancer**
Please select how treatment will be administered: ☐ As a single agent ☐ In combination with oxaliplatin ☐ Other: ______
Will combination treatment with oxaliplatin be with or without Avastin (bevacizumab)? ☐ With bevacizumab ☐ Without bevacizumab

For ALL Continuation Requests **(clinical documentation required):**
☐ Yes ☐ No Has the patient experienced disease progression, developed intolerance, or had an adverse event while on Xeloda or capecitabine)?
→ Please select: ☐ Disease progression ☐ Treatment intolerance ☐ Adverse event
If yes, which medication did the patient experience this on: ☐ Xeloda ☐ capecitabine

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H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* ________________________ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.