

**Physician's Prior Authorization Questionnaire
Xeloda®**

Patient:

ID#:

DOB:

Patient Address:

Xeloda® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? *(Please specify the type and severity of the cancer.)* _____

2. Has a prior chemotherapy regimen been used for this diagnosis? Yes No
If Yes, please list the prior medications: _____

3. Will other chemotherapy agents be used while on Xeloda®? Yes No
If Yes, please list: _____

4. What dose is being requested (mg/day)? _____

Xeloda® will be shipped to the patient from our Specialty Pharmacy.

Physician's Signature

Date

Please **Print** Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx