

MEDICAL PHARMACY PRIOR AUTHORIZATION REQUEST FORM

XIAFLEX®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 801-213-1547. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: Healthy U: 833-981-0212, Individual Exchange: 833-981-0214, Commercial Groups: 833-981-0213, Advantage U: 888-605-0858

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:	HCPCS Code:	

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: Xiaflex® (collagenase clostridium histolyticum)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
DUPUYTREN'S CONTRACTURE			
1. Does the member have a confirmed diagnosis of Dupuytren's contracture with palpable cord of at least one finger?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the palpable cord involve the metacarpophalangeal (MP) joint or the proximal interphalangeal (PIP) joint?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Has the member had a fasciectomy or fasciotomy within 90 days prior to the first injection?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
PEYRONIE'S DISEASE			
1. Does the member have a confirmed diagnosis of Peyronie's disease with palpable plaque?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the prescribing provider an urologist?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does member have a curvature deformity of at least 30 degrees at the start of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Is the curvature deformity caused by congenital ventral penile curvature or curvature associated with epispadias?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. Is member experiencing clinical complications from Peyronie's such as pain and/or difficulty with urination?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

REAUTHORIZATION

DUPUYTREN'S CONTRACTURE

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1. Does the member meet the initial criteria?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Does documentation show the MP or PIP contracture remains?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Was the last treatment \geq 4 weeks ago?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Has the member received > 3 injections per cord?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
PEYRONIE'S DISEASE			
1. Does documentation show that a maximum of 4 treatment cycles have been received?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Is the member experiencing clinical complications from Peyronie's such as pain and/or difficulty with urination?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Does documented curvature deformity remain at \geq 15 degrees since the last treatment cycle?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Do clinic notes document that a penile modeling procedure has been performed 1 to 3 days after each injection?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Was the last treatment cycle \geq 6 weeks ago?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy PHARM- M011
 Origination Date: 09/01/2019
 Reviewed/Revised Date: 01/27/2021
 Next Review Date: 01/27/2022
 Current Effective Date: 02/01/2021

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