Xiaflex

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical (POS Code 24)*
❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)*
❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

What is the ICD-10 code? _____

Clinical Criteria Questions:

1. What is the diagnosis?

❒ Dupuytren's contracture, *Continue to 2*
❒ Peyronie's disease, *Continue to 10*
❒ Other, please specify. _____, *No further questions*

Send completed form to: Priority Partners Fax: 1-866-212-4756

 Xiaflex SGM 3043-A – 10/2023.

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.hopkinshealthplans.org

2. Prior to initiating the current course of treatment for the cord with the requested medication, did/does the patient have a finger flexion contracture with a palpable cord in a metacarpophalangeal joint or a proximal interphalangeal joint? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) or medical record indicating the affected joint.

❒ Yes - In a metacarpophalangeal joint ***ACTION REQUIRED****: Submit supporting documentation, Continue to 3*
❒ Yes - In a proximal interphalangeal joint ***ACTION REQUIRED****: Submit supporting documentation, Continue to 3*

❒ No, *Continue to 3*

3. Prior to initiating the current course of treatment for the cord with the requested medication, was/is the contracture at least 20 degrees? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) or medical record indicating the degree of pretreatment contracture. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. Prior to initiating the current course of treatment for the cord with the requested medication, did the patient have a positive table top test, defined as the inability to simultaneously place the affected finger(s) and palm flat against a table? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) or medical record indicating a positive table top test.
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Is the patient continuing with a treatment course for the same cord?

❒ Yes - continuing with a treatment course for the same cord, *Continue to 6*

❒ No - starting a treatment course for new cord, *Continue to 7*

❒ No - starting a treatment course for recurrence in a previously treated cord, *Continue to 7*

❒ Other, please specify. _____, *No further questions*

6. How many injections has the patient received as part of the current treatment course? ***ACTION REQUIRED***: If less than 3 injections, attach supporting chart note(s) or medical record indicating the number of injections the patient has received for each cord being treated.

_____injections per current treatment course*, Continue to 7*

7. Will the requested drug be used for cosmetic use (e.g., cellulite reduction treatment)?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Will the requested medication be administered by a healthcare provider experienced in injection procedures of the hand and in the treatment of Dupuytren's contracture?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Will the patient receive up to 3 injections maximum (4 weeks apart) as part of the current treatment?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

10. Does the patient have stable Peyronie's disease without clinical changes (e.g., worsening curvature) for at least three months?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Prior to initiating therapy with the requested medication, did/does the patient have a palpable plaque and curvature deformity of at least 30 degrees and less than 90 degrees? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) or medical record indicating the pretreatment deformity curvature and the presence of a palpable plaque.
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Does the patient have intact erectile function (with or without medication)? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) or medical record indicating intact erectile function (with or without medication).
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Is the patient 18 years of age or older?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Is the patient continuing treatment with the requested medication for Peyronie's disease?
❒ Yes, *Continue to 15*
❒ No, *Continue to 17*

15. What is the current curvature of deformity? ***ACTION REQUIRED***: If 15 degrees or greater, attach supporting chart note(s) or medical record indicating the current deformity curvature.

_____degrees, *No further questions*

16. How many injections has the patient received, including any injections patient already received during current and any previous treatment? ***ACTION REQUIRED***: If less than 8 injections, attach supporting chart note(s) or medical record indicating the number of injections the patient has received.

_____injections*, Continue to 17*

17. Will the requested medication be used for cosmetic use (e.g., cellulite reduction treatment)?
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. Will the requested medication be administered by a healthcare provider experienced in the treatment of urological disease?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. Will the requested medication be administered by a healthcare provider who has completed the requested medication REMS program requirements?
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

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20. Will the patient receive a maximum of one treatment course with a total of 8 injections or less, including any injections patient already received during current and any previous treatment?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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