

Prior Authorization Criteria

Xiaflex (collagenase clostridium histolyticum)

All requests for Xiaflex (collagenase clostridium histolyticum) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Coverage may be provided with a diagnosis of **Dupuytren's Contracture** and the following criteria is met:

- Member must be 18 years of age or older
- Documentation the member has one of the following:
 - a finger flexion contracture with a palpable cord of at least one finger (other than the thumb)
 - a positive "table top test" defined as the inability to simultaneously place the affected finger(s) and palm flat against a table top
- Documentation that the flexion deformity results in functional limitations
- Documentation of which cords on which hand are being treated and dates of treatment
- A maximum of two cords in the same hand may be treated during a single treatment visit (all treatment visits must be at least 4 weeks apart)
- A cord may not be injected more than 3 times and at an interval less than 4 weeks
- Must not have received a surgical treatment (e.g. fasciectomy, fasciotomy) on the selected primary joint within 90 days before the first injection
- **Initial Duration of Approval:** 4 months

Coverage may be provided with a diagnosis of **Peyronie's disease** and the following criteria is met:

- Member must be 18 years of age or older
- Documentation of a palpable plaque and curvature deformity of at least 30 degrees at the start of therapy
- Documentation the member has at least one of the following:
 - phimosis
 - urinary retention
 - pain related to contracture
- Injections for Peyronie's disease are limited to 4 treatment cycles. (Each cycle consists of 2 Xiaflex injections and one remodeling procedure.)
- **Exclusion criteria:**
 - sexual or erectile dysfunction associated with Peyronie's disease
- **Initial Duration of Approval:** 6 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.



Updated: 04/2019
PARP Approved: 04/2019

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

**XIAFLEX (COLLAGENASE CLOSTRIDIUM HISTOLYTICUM)
PRIOR AUTHORIZATION FORM**

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway HealthSM Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____ pounds or _____ kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Medication Initiated:

Billing Information

This medication will be billed: at a pharmacy **OR**
 medically (if medically please provide a
JCODE:
Place of Service: Hospital Provider's office Member's home Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: Dupuytren's Contracture Peyronie's Disease Other: _____

For Dupuytren's Contracture Please select all of the following that apply (*please attach supporting documentation*):

- the member has a finger flexion contracture with a palpable cord of at least one finger (other than the thumb)
- a positive "table top test" defined as the inability to simultaneously place the affected finger(s) and palm flat against a table top
- the flexion deformity is causing functional limitations

Which cord(s) are being treated? _____

Dates of treatment: _____

Was the cord previously treated? Yes No

If yes when? _____

Has the member received a surgical treatment on the selected primary joint 90 days or less before the date of the first scheduled injection? Yes No

For Peyronie's Disease:

Does the member have a palpable plaque and curvature deformity of at least 30 degrees? Yes No

Please select all of the following that apply (*please attach supporting documentation*):

- the member has phimosis
- the member is experiencing urinary retention
- the member is experiencing pain related to the contracture

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature

Date
