



Updated: 08/2022  
DMMA Approved: 08/2022

**Request for Prior Authorization for Xiaflex (collagenase clostridium histolyticum)**  
**Website Form – [www.highmarkhealthoptions.com](http://www.highmarkhealthoptions.com)**  
**Submit request via: Fax - 1-855-476-4158**

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.

**Xiaflex (collagenase clostridium histolyticum) Prior Authorization Criteria:**

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
- **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
- Must be prescribed by or in consultation with a urologist
- Documentation the member has stable disease defined as symptoms that have remained unchanged for at least 3 months
- Documentation of a palpable plaque and curvature deformity of at least 30 degrees and less than 90 degrees at the start of therapy
- Erectile function must be intact
- 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



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- **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.



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**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 Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158  
If needed, you may call to speak to a Pharmacy Services Representative.  
**PHONE:** (844) 325-6253 Monday through Friday 8:00am to 7:00pm

**PROVIDER INFORMATION**

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

**MEMBER INFORMATION**

Member Name:	DOB:
Member ID:	Member weight:      Height:

**REQUESTED DRUG INFORMATION**

Medication:	Strength:
Directions:	Quantity:      Refills
Is the member currently receiving requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Medication Initiated:
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**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: \_\_\_\_\_

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? \_\_\_\_\_



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Member Name:  
Member ID:

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 and less than 90 degrees ?  
 Yes  No

Does the member have stable disease (*please submit documentation the member’s symptoms have remained unchanged for at least 3 months*)?  Yes  No

Is erectile function intact?  Yes  No

**CURRENT or PREVIOUS THERAPY**

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

**SUPPORTING INFORMATION or CLINICAL RATIONALE**

**Prescribing Provider Signature** **Date**