PriorityHealth

Pharmacy
PRIOR AUTHORIZATION FORM

Last Reviewed: September 2010

For Prior Authorization, please fax to: (877) 974-4411 toll free, or (616) 942-8206

This from applies to: ☒ **Commercial Plan** ☒ **Medicaid Plan** ☐ **Medicare Plan**

Note: Prior authorization for Medicare Plan is not required with a diagnosis of Contracture of Palmar Fascia (728.6).

Xiaflex® (collagenase)

☐ **URGENT** (life threatening)

☐ **Non-Urgent** (standard review)

A claim involving "urgent care" applies when then standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

______________________________ ____________________

Provider Signature Date

PRODUCT INFORMATION

☒ Xiaflex 0.9 mg vial

Start Date: ____________________

Number of vials: ____________________

Joints being treated: ____________________

BILLING INFORMATION

Place of administration:

☐ Provider's Office
☐ Other: ____________________

Billing Options:

☐ Physician buy and bill
☐ Preferred Specialty Vendor
☐ Other: ____________________

PriorityHealth®

PRIORITY HEALTH PRECERTIFICATION REQUIRMENTS
Authorization for Xiaflex® (collagenase) requires the following information to certify:

Patient must have met the following requirements:

1. Diagnosis of Dupuytren's contracture
2. Flexion contracture of at least one finger, other than the thumb, of greater than or equal to 20 degrees at the MP or PIP joints
3. Patient must be free of chronic muscular, neurological, or neuromuscular disorders affecting the hands
4. Patient is **not** a candidate for surgical palmar fasciotomy

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION
Authorization for Xiaflex® (collagenase) requires the following information to certify:

A. **What is the patient's diagnosis?**
   a. ☐ Dupuytren's contracture
   b. ☐ *other diagnosis:* ______________________________
   rationale for use: ______________________________

   Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

B. **What is the degree of flexion contracture?** ______________________________

C. **Is the patient free of chronic muscular, neurological, or neuromuscular disorders affecting the hands?**
   ☐ Yes
   ☐ No – Rationale for use: ______________________________

D. **Is the patient a candidate for surgical palmar fasciotomy?**
   ☐ No
   ☐ Yes – Rationale for use: ______________________________

E. **Please provide any additional information to be considered for review if all of the above criteria are not met:**

   ____
   ____

PRIORITY MEDICARE PLANS

Note: Priority Health Medicare applies CMS national and local coverage determination criteria when available for Part B drugs. If no national determination criteria or local coverage determination criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX