PriorityHealth

Medical prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)**
☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Xiaflex® (collagenase)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Phone: _____ Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

☐ New Request ☐ Continuation Request

Drug product: ☒ Xiaflex 0.9 mg vial

Dose:_____ **Dose Frequency**:_____

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Date of next dose: _____

Body Weight: _____

Administration:
☐ Physician's Office
☐ Outpatient Infusion
Facility: _____ NPI: _____ Fax #: _____
☐ Home infusion
Agency: _____ NPI: _____ Fax #: _____

Billing:
☐ Physician Buy and Bill
☐ Facility Buy and Bill
☐ Specialty Pharmacy
Pharmacy: _____ NPI: _____ Fax #: _____

ICD-10 Diagnosis Code(s): _____

All fields must be complete and legible for review. Your office will receive a response via fax.

No changes made since 01/2020
Last reviewed 01/2021

Precertification Requirements

Before this drug is covered, the patient must meet the requirements for one of the following conditions (please provide supporting documentation):

1. Must have Dupuytren's contracture with
    a. 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
    b. Patient must be free of chronic muscular, neurological, or neuromuscular disorders affecting the hands
    c. Xiaflex is an alternative to surgical intervention. For coverage consideration, please provide the medical reason that surgery would not be an option for the patient.

Note: Maximum dose is 3 injections per cord every 4 weeks, with a maximum of 2 injections per hand per visit (which may be administered as either 1 injection per cord on 2 cords affecting 2 different joints OR 2 injections on 1 cord affecting 2 joints).

2. Must have Peyronie's disease with:
    a. Penile curvature of 30 degrees or more for 12 months or longer,
    b. Must first try intralesional verapamil or pentoxifylline, and
    c. Erections must be painful

Note: Priority Health considers Peyronie's disease cosmetic in the absence of painful erections. Priority Health covers up to 4 treatment cycles for Peyronie's disease. Each treatment cycle consists of two Xiaflex injections given one to three days apart. Each subsequent treatment cycle must be six-weeks apart and is only authorized if the patient's penile curvature is 15 degrees or more.

Note: Authorization for indications, dosing, or a route of administration 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 appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Dupuytren's contracture
- ☐ Peyronie's disease
- ☐ Other – the patient's condition is: _____

Complete the following information for Dupuytren's contracture:

A. Has documentation been provided indicating the patient has flexion contracture of at least one finger (other than the thumb) greater than or equal to 20 degrees at the MP or PIP joints?

- ☐ Yes
- ☐ No: explain _____

B. Does the patient have any diagnoses of chronic muscular, neurological, or neuromuscular disorders affecting the hands?

- ☐ Yes: explain _____
- ☐ No

C. Is the patient a candidate for surgical palmar fasciotomy?

- ☐ Yes
- ☐ No

D. What degree of penile curvature does the patient have? _____

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Last reviewed 01/2021

Complete the following information for Peyronie's disease:

A. **Which of the following medications has the patient tried?**
- ☐ Verapamil (intralesional injection)
- ☐ Pentoxifylline

B. **What degree of penile curvature does the patient have?** _____

C. **How long has the patient had penile curvature?** _____

D. **Does the patient have painful erections?** ☐ Yes ☐ No

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Last reviewed 01/2021