HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM
XIAFLEX®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 801-213-1547.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 833-404-4300

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Xiaflex® (collagenase clostridium histolyticum)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
DUPUYTREN'S CONTRACTURE			
1. Does the member have a confirmed diagnosis of Dupuytren's contracture with palpable cord of at least one finger?	☐	☐	**Please provide documentation**
2. Is the member 18 years of age or older?	☐	☐	
3. Does the palpable cord involve the metacarpophalangeal (MP) joint or the proximal interphalangeal (PIP) joint?	☐	☐	**Please provide documentation**
4. Has the member had a fasciectomy or fasciotomy within 90 days prior to the first injection?	☐	☐	**Please provide documentation**
PEYRONIE'S DISEASE			
1. Does the member have a confirmed diagnosis of Peyronie's disease with palpable plaque?	☐	☐	**Please provide documentation**
2. Is the member 18 years of age or older?	☐	☐	
3. Is the prescribing provider an urologist?	☐	☐	
4. Does member have a curvature deformity of at least 30 degrees at the start of therapy?	☐	☐	**Please provide documentation**
5. Is the curvature deformity caused by congenital ventral penile curvature or curvature associated with epispadias?	☐	☐	**Please provide documentation**
6. Is member experiencing clinical complications from Peyronie's such as pain and/or difficulty with urination?	☐	☐	**Please provide documentation**

REAUTHORIZATION			
DUPUYTREN'S CONTRACTURE			
1. Does the member meet the initial criteria?	☐	☐	**Please provide documentation**
2. Does documentation show the MP or PIP contracture remains?	☐	☐	**Please provide documentation**
3. Was the last treatment ≥ 4 weeks ago?	☐	☐	**Please provide documentation**
4. Has the member received > 3 injections per cord?	☐	☐	**Please provide documentation**
PEYRONIE'S DISEASE			
1. Does documentation show that a maximum of 4 treatment cycles have been received?	☐	☐	**Please provide documentation**
2. Is the member experiencing clinical complications from Peyronie's such as pain and/or difficulty with urination?	☐	☐	**Please provide documentation**
3. Does documented curvature deformity remain at ≥ 15 degrees since the last treatment cycle?	☐	☐	**Please provide documentation**
4. Do clinic notes document that a penile modeling procedure has been performed 1 to 3 days after each injection?	☐	☐	**Please provide documentation**
5. Was the last treatment cycle ≥ 6 weeks ago?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

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Policy: PHARM-CHIP-M011
Origination Date: 07/01/2024
Reviewed/Revised Date: 07/29/2024
Next Review Date: 07/29/2025
Current Effective Date: 08/01/2024