



Fax completed form to: (855) 840-1678

If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

Xiaflex (collagenase clostridium histolyticum)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency: Standard Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)**Medication requested: (please specify name, strength, and dosing schedule):** Xiaflex (collagenase clostridium histolyticum) 0.9mg vial

ICD10:

Dose: Frequency of therapy:

Quantity:

Duration of therapy:

J-Code:

Has your patient previously been treated with Xiaflex?

 Yes No

How many Xiaflex injections has the patient received?

- 1 injection
- 2 injections
- 3 injections
- 4 injections
- 5 injections
- 6 injections
- 7 injections
- 8 injections

(if yes) Please provide past treatment details (including injection sites and dates received).

(if Dupuytren's) Is the requested dose 0.58 mg per injection into an affected cord?

 Yes No

(if Dupuytren's) Will a maximum of two cords (up to 1.16 mg) be injected per treatment visit? Please Note: If there are other affected cords in the same hand, treatment may be administered to those on a different day.

 Yes No

(if Dupuytren's) Will subsequent doses for each affected cord be administered no sooner than 4 weeks following the previous Xiaflex injection?

 Yes No

(if Peyronie's) Is the requested dose up to a total of eight 0.58 mg injections per Peyronie's plaque (four dosing cycles, each consisting of two 0.58 mg injections given 1 to 3 days apart) or less?

 Yes No(if yes) Will the requested dosing cycles be separated by at least 6 weeks from the previous Xiaflex cycle? Yes No**Where will this medication be obtained?**

- Accredo Specialty Pharmacy**
- Hospital Outpatient
- Retail pharmacy
- Other (please specify):

- Home Health / Home Infusion vendor
- Physician's office stock (billing on a medical claim form)

****Cigna's nationally preferred specialty pharmacy******Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557**

Facility and/or doctor dispensing and administering medication:

Facility Name:

State:

Tax ID#:

Address (City, State, Zip Code):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? Yes No

Diagnosis related to use:

- Cosmetic uses (Note: An example of cosmetic use includes cellulite treatment.)
 Dupuytren's contracture
 Peyronie's disease
 Other (please specify):

Clinical questions:

(if Dupuytren's) As part of the current treatment course, will the patient be treated with up to three injections (maximum) per affected cord? Yes No

(if Dupuytren's) Does the patient have at least one palpable cord in the affected hand? Yes No

(if Dupuytren's) Does the patient have a contracture of a metacarpophalangeal or proximal interphalangeal joint that is associated with the palpable cord? Yes No

(if Dupuytren's) At baseline (prior to initial injection of Xiaflex), does the contracture measure at least 20 degrees? Yes No

(if Dupuytren's) Will Xiaflex be administered by a healthcare provider experienced in injection procedures of the hand and in the treatment of Dupuytren's contracture? Yes No

(if Peyronie's) Does the patient have at least one palpable plaque in the penis? Yes No

(if Peyronie's) Has the patient previously been treated with Xiaflex for Peyronie's disease?

- Yes, a complete course (8 injections)
 Yes, a partial course (7 or fewer injections)
 No

(if no previous treatment for Peyronie's) At baseline (prior to initial injection of Xiaflex), does the patient have a penile curvature deformity of at least 30 degrees? Yes No

(if previous treatment for Peyronie's) Does the patient have a penile curvature deformity of at least 15 degrees? Yes No

(if Peyronie's) Will Xiaflex be administered by a healthcare provider experienced in the treatment of male urological diseases? Yes No

Additional pertinent information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature: _____ **Date:** _____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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