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
(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 or less? ☐ Yes ☐ No

(if yes) Is the requested subsequent dose for each affected cord administered no sooner than 4 weeks following the previous Xiaflex injection? ☐ Yes ☐ No

(if yes) Is the requested dose for a maximum of two cords (up to 1.16 mg) injected per treatment visit (If there are other affected cords in the same hand, treatment may be administered to those on a different day)? ☐ Yes ☐ No

(if Peyronie's) Is the requested dose 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 (for example, cellulite of buttocks) ☐ Dupuytren's contracture ☐ Peyronie's disease
☐ Other (please specify):

Clinical questions:

(if Dupuytren's) Does your patient have a palpable cord? Yes ☐ No ☐

(if Dupuytren's) Does your patient have functional impairment as manifested by a metacarpophalangeal (MCP) joint or proximal interphalangeal (PIP) joint contracture of 20 degrees or greater at baseline (prior to initial injection of Xiaflex)? Yes ☐ No ☐

(if Dupuytren's) As part of the current treatment course, will your patient be treated with MORE THAN a total of three injections (maximum) per affected cord? Yes ☐ No ☐

(if Dupuytren's) Will the medication 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 your patient have a palpable plaque? Yes ☐ No ☐

(if Peyronie's) Has your patient previously been treated with this medication? Yes ☐ No ☐

(if no previous Xiaflex treatment for Peyronie's) Is there a penile curvature deformity of at least 30 degrees prior to the start of therapy? Yes ☐ No ☐

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

(if Peyronie's) Will the patient be treated with more than a total of 8 injections (maximum) per Peyronie's plaque? Yes ☐ No ☐

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

Additional pertinent information: (*please include clinical reasons for drug, relevant lab values, etc.)*:

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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