FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Xiaflex® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Dupuytren's contracture

❑ Peyronie's disease

❑ Other diagnosis: _____ ICD-10 Code(s): _____

For Dupuytren's contracture, answer the following:

Does the patient have a diagnosis of Dupuytren's contracture with a palpable cord? ❑ **Yes** ❑ **No**

Does the patient has a positive "table top test" (defined as the inability to simultaneously place the affected finger and palm flat against a table top)? ❑ **Yes** ❑ **No**

Does the patient have a documented contracture of at least 20 degrees flexion for a metacarpophalangeal joint or a proximal interphalangeal joint? ❑ **Yes** ❑ **No**

Does the patient have a flexion deformity that results in functional limitations? ❑ **Yes** ❑ **No**

For Peyronie's disease, answer the following:

Does the patient have a palpable plaque and curvature deformity of at least 30 degrees at the start of therapy? ❑ **Yes** ❑ **No**

Does the patient have plaques that involve the penile urethra? ❑ **Yes** ❑ **No**

Does the patient have a curvature deformity that results in pain (e.g., pain upon erection or intercourse)? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization, also answer the following question:

Does the patient have a new plaque that results in a curvature deformity? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.