



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

### Xiaflex® Prior Authorization Request Form

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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:
<input type="checkbox"/> Check if <b>generic substitution</b> is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>		

### 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?

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

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