HIGHMARK HEALTH OPTIONS

Updated: 06/2025
Approved: 06/2025

Request for Prior Authorization for Xiaflex (collagenase clostridium histolyticum)
Website Form – www.wv.highmarkhealthoptions.com
Submit request via: Fax - 1-833-547-2030.

All requests for **Xiaflex (collagenase clostridium histolyticum)** require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Xiaflex (collagenase clostridium histolyticum) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of **Dupuytren's Contracture** and the following criteria is met:

- Member must be 18 years of age or older
- Documentation the member has one of the following:
  - a finger flexion contracture with a palpable cord of at least one finger (other than the thumb)
  - a positive "table top test" defined as the inability to simultaneously place the affected finger(s) and palm flat against a table top
- Documentation that the flexion deformity results in functional limitations
- Documentation of which cords on which hand are being treated and dates of treatment
- A maximum of two cords in the same hand may be treated during a single treatment visit (all treatment visits must be at least 4 weeks apart)
- A cord may not be injected more than 3 times and at an interval less than 4 weeks
- Must not have received a surgical treatment (e.g. fasciectomy, fasciotomy) on the selected primary joint within 90 days before the first injection
- **Duration of Approval:** 4 months

Coverage may be provided with a diagnosis of **Peyronie's disease** and the following criteria is met:

- Member must be 18 years of age or older
- Must be prescribed by or in consultation with a urologist
- Documentation the member has stable disease defined as symptoms that have remained unchanged for at least 3 months
- Documentation of a palpable plaque and curvature deformity of at least 30 degrees and less than 90 degrees at the start of therapy
- Erectile function must be intact
- Injections for Peyronie's disease are limited to 4 treatment cycles. (Each cycle consists of 2 Xiaflex injections and one remodeling procedure.)
- **Exclusion criteria:**
  - sexual or erectile dysfunction associated with Peyronie's disease
- **Duration of Approval:** 6 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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XIAFLEX (COLLAGENASE CLOSTRIDIUM HISTOLYTICUM) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (833)-547-2030.**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: 1-844-325-6251 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No		

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE: _____
Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

For Dupuytren's Contracture

Please select all of the following that apply (*please attach supporting documentation*:

☐ the member has a finger flexion contracture with a palpable cord of at least one finger (other than the thumb)

☐ a positive "table top test" defined as the inability to simultaneously place the affected finger(s) and palm flat against a table top

☐ the flexion deformity is causing functional limitations

Which cord(s) are being treated? _____
Dates of treatment: _____
Was the cord previously treated? ☐ Yes ☐ No
If yes when? _____

Has the member received a surgical treatment on the selected primary joint 90 days or less before the date of the first scheduled injection? ☐ Yes ☐ No

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XIAFLEX (COLLAGENASE CLOSTRIDIUM HISTOLYTICUM)
PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (833)-547-2030.**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: 1-844-325-6251 Mon – Fri 8 am to 7 pm

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

MEDICAL HISTORY (Complete for ALL requests)

For Peyronie's Disease:

Does the member have a palpable plaque and curvature deformity of at least 30 degrees and less than 90 degrees ?
☐ Yes ☐ No

Does the member have stable disease (*please submit documentation the member's symptoms have remained unchanged for at least 3 months)*? ☐ Yes ☐ No

Is erectile function intact? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date