Blue Cross Blue Shield Blue Care Network of Michigan

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Blue Cross Medicare Plus Blue℠ PPO and BCN Advantage℠ Medication Authorization Request Form Xiaflex® (Collagenase clostridium histolyticum) J0775

The most efficient way to request authorization is to use the NovoLogix® system. To access NovoLogix, visit bcbsm.com/providers and log in to Provider Secured Services. Click the link for Medical Prior Authorization. As an alternative, you can use this form to request authorization. Complete this form and fax to 1-866-392-6465. If you have any questions regarding this process, contact the Pharmacy Clinical Help Desk at 1-800-437-3803.

PATIENT INFORMATION	PHYSICIAN INFORMATION
Name	**Name**
ID Number	**Specialty**
Date of birth ☐Male ☐Female	**Address**
Diagnosis (include ICD-10)	**City /State/Zip**
Drug Name	**Phone:** ( ) - **Fax:** ( ) -
Dose and Quantity	**NPI**
Directions	**Contact Person**
Date of Services	**Contact Person's Phone / Ext.**

STEP 1: DISEASE STATE INFORMATION

1. Initial or Continuation request? ☐ Initial ☐ Continuation. Date of last dose _____
2. Has the prescriber completed the training required through the Xiaflex® Risk Evaluation and Mitigation Strategy (REMS) Program? ☐ Yes ☐ No
3. Please provide the patient's diagnosis. ☐ Dupuytren's Contracture ☐ Peyronie's Disease ☐ Other diagnosis_____
4. Does the patient have a finger contracture with a palpable cord that involves either the metacarpophalangeal (MP), or the proximal interphalangeal (PIP) joint? ☐ Yes ☐ No
5. Please indicate how you will be performing the injection procedure during the treatment visit?
   - ☐ Two palpable cords affecting two joints will be injected. (Perform up to two injections in the same hand during a treatment visit.)
   - ☐ One palpable cord affecting two joints in the same finger will be injected at two locations during the treatment visit. (Perform up to two injections in the same hand during a treatment visit.)
   - ☐ Patient requires greater than 2 injections in the same hand due to other palpable cords with contractures of metacarpophalangeal (MP) or proximal interphalangeal (PIP) joint.
   - ☐ Other. Please provide an explanation of how you will be performing the injection procedure as well as rationale.

6. Has the member received treatment with Xiaflex® in a palpable cord involving the metacarpophalangeal (MP) or proximal interphalangeal (PIP) joint in the past 12 months? ☐ Yes. Please specify how many times the patient has received Xiaflex® for this condition_____, and the reason for more injections._____ ☐ No
7. What therapy has been tried for Peyronie's disease? Please select all that apply. ☐ Intralesional verapamil ☐ Pentoxifylline ☐ Verapamil gel ☐ Other. Please specify._____ ☐ None
8. ***Continuation, Peyronie's Disease***: Please list the degree of curvature deformity at start of therapy (please list in degrees):_____
9. Please specify how many treatment cycles the patient has received of Xiaflex® (Note: one treatment cycle consists of two injections and one modeling procedure)_____
10. Is the current curvature deformity less than 15 degrees? ☐ Yes ☐ No
11. Please attach any chart notes or additional documentation and submit to plan. ***(Required)***

Coverage won't be provided if the prescribing physician's signature and date aren't reflected on this document.

☐ Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

Physician's Name	Physician's Signature	Date

Step 2: Checklist	☐ Form Completely Filled Out ☐ Attached Chart Notes	☐ Concurrent Medical Problems ☐ Prior Therapies
Step 3: Submit	**Fax the completed form to 1-866-392-6465**	

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