Xiaflex

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 Xiaflex SGM 3043-A – 12/2024.

Criteria Questions:

1. What is the diagnosis?

❒ Dupuytren's contracture, *Continue to 2*

❒ Peyronie's disease, *Continue to 11*

❒ Other, please specify. _____, *No further questions*

2. Is the patient 18 years of age or older?
❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

3. Prior to initiating the current course of treatment for the cord with the requested medication, did/does the patient have a finger flexion contracture with a palpable cord in a metacarpophalangeal joint or a proximal interphalangeal joint? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) or medical record indicating the affected joint.

❒ Yes - In a metacarpophalangeal joint ***ACTION REQUIRED****: Submit supporting documentation, Continue to 4*
❒ Yes - In a proximal interphalangeal joint ***ACTION REQUIRED****: Submit supporting documentation, Continue to 4*

❒ No, *Continue to 4*

4. Prior to initiating the current course of treatment for the cord with the requested medication, was/is the contracture at least 20 degrees? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) or medical record indicating the degree of pretreatment contracture.
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Prior to initiating the current course of treatment for the cord with the requested medication, did the patient have a positive table top test, defined as the inability to simultaneously place the affected finger(s) and palm flat against a table? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) or medical record indicating a positive table top test.
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Is the patient continuing with a treatment course for the same cord?

❒ Yes - continuing with a treatment course for the same cord, *Continue to 7*

❒ No - starting a treatment course for new cord, *Continue to 8*

❒ No - starting a treatment course for recurrence in a previously treated cord, *Continue to 8*

❒ Other, please specify. _____, *No further questions*

7. How many injections has the patient received as part of the current treatment course? ***ACTION REQUIRED***: If less than 3 injections, attach supporting chart note(s) or medical record indicating the number of injections the patient has received for each cord being treated.
_____injections per current treatment course, *Continue to 7*

8. Will the requested drug be used for cosmetic use (e.g., cellulite reduction treatment)?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Will the requested medication be administered by a healthcare provider experienced in injection procedures of the hand and in the treatment of Dupuytren's contracture?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Will the patient receive up to 3 injections maximum (4 weeks apart) as part of the current treatment?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

11. Does the patient have stable Peyronie's disease without clinical changes (e.g., worsening curvature) for at least three months?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Prior to initiating therapy with the requested medication, did/does the patient have a palpable plaque and curvature deformity of at least 30 degrees and less than 90 degrees? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) or medical record indicating the pretreatment deformity curvature and the presence of a palpable plaque.
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Does the patient have intact erectile function (with or without medication)? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) or medical record indicating intact erectile function (with or without medication).
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Is the patient 18 years of age or older?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. Is the patient continuing treatment with the requested medication for Peyronie's disease?
❒ Yes, *Continue to 16*
❒ No, *Continue to 18*

16. What is the current curvature of deformity? ***ACTION REQUIRED***: If 15 degrees or greater, attach supporting chart note(s) or medical record indicating the current deformity curvature.

_____degrees, ***ACTION REQUIRED****: Submit supporting documentation, Continue to 17*

17. How many injections has the patient received, including any injections patient already received during current and any previous treatment? ***ACTION REQUIRED***: If less than 8 injections, attach supporting chart note(s) or medical record indicating the number of injections the patient has received.

_____injections ***ACTION REQUIRED****: Submit supporting documentation, Continue to 18*

18. Will the requested medication be used for cosmetic use (e.g., cellulite reduction treatment)?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. Will the requested medication be administered by a healthcare provider experienced in the treatment of urological disease?
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

20. Will the requested medication be administered by a healthcare provider who has completed the requested medication REMS program requirements?
❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

21. Will the patient receive a maximum of one treatment course with a total of 8 injections or less, including any injections patient already received during current and any previous treatment?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com