Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Xiaflex
(collagenase clostridium histolyticum)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested: (*please specify name, strength, and dosing schedule)*:
☐ Xiaflex (collagenase clostridium histolyticum) 0.9mg vial ICD10:

Quantity: Duration of therapy: J-Code:
Has your patient previously been treated with Xiaflex? ☐ Yes ☐ No
(if yes) Please provide past treatment details (including injection sites and dates received).

Where will this medication be obtained?
☐ US Bioservices ☐ Home Health / Home Infusion vendor
☐ Prescriber's office stock (billing on a medical claim form) ☐ Other (please specify):

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:
☐ Cosmetic uses ☐ Dupuytren's contracture ☐ Peyronie's disease ☐ Other (please specify):

Clinical questions:
(if Dupuytren's) Does your patient have a palpable cord? Yes ☐ No ☐
(if Dupuytren's) For each finger being treated, does your patient have a metacarpophalangeal (MCP) joint or proximal interphalangeal (PIP) joint contracture of 20 degrees or greater at baseline (prior to initial injection of Xiaflex)? Yes ☐ No ☐
(if Dupuytren's) Will the patient be treated with MORE THAN a total of three injections (maximum) per affected cord? Yes ☐ No ☐
(if Dupuytren's) Will the medication be administered by a healthcare provider experienced in the treatment of Dupuytren's contracture and injection procedures of the hand? Yes ☐ No ☐

(if Peyronie's) Does your patient have a palpable plaque? Yes ☐ No ☐
(if Peyronie's) Is there a curvature deformity of between 30 degrees and 90 degrees at the start of therapy? Yes ☐ No ☐
(if Peyronie's) Has the patient had an incomplete or partial course of Xiaflex injections (maximum is 8 injections in total)? Yes ☐ No ☐
(if yes) Does the patient have a curvature deformity of at least 15 degrees? Yes ☐ No ☐
(if Peyronie's) Will the patient be treated with MORE THAN a total of 8 injections (maximum) per Peyronie's plaque? Yes ☐ No ☐
(if Peyronie's) Will the medication be administered by a healthcare provider experienced in the treatment of male urological diseases? Yes ☐ No ☐

Additional pertinent information: (*please include clinical reasons for drug, relevant lab values, etc.)*:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005