



## PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

**Xiaflex**

**Phone: 800-728-7947**

**Fax back to: 866-880-4532**

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>	
	<b>Supervising Physician:</b>	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

**Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.**

Q1. What diagnosis is this drug being prescribed for (pick one)? \*

- ☐ Dupuytren's contracture (answer questions 3-7)  
☐ Peyronie's disease (answer questions 3 and 8)  
☐ Other

Q2. Please provide ICD code(s) for diagnosis.

Q3. Please indicate location of administration.

- ☐ Home  
☐ Physician office (drug from office stock - buy and bill)  
☐ Physician office (MEMBER to obtain drug from PHARMACY with a prescription)  
☐ Other

Q4. Is the patient 18 years or older?

- ☐ Yes ☐ No

Q5. Specify the prescriber's specialty.

- ☐ Orthopedic surgery



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<input type="checkbox"/> Hand surgery <input type="checkbox"/> Plastic surgery <input type="checkbox"/> Urology <input type="checkbox"/> Other (please specify)	
Q6. If request is for Dupuytren's contracture, does the patient have fixed-flexion contractures of the metacarpophalangeal joint or proximal interphalangeal joint of 20 degrees or more (excluding the thumb)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. If request is for Dupuytren's contracture, does the patient have a palpable cord? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. If request is for Dupuytren's contracture and the patient has multiple cords with contractures, will patient be getting NO MORE than 2 injections per treatment session? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. If request is for Peyronie's disease, does the patient have a palpable plaque causing greater than 30 degree penile curvature at treatment initiation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. Additional Comments	

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

☐ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been



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**Supervising Physician:**

decided.

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