XIAFLEX®
collagenase clostridium histolyticum

Prescription and Insurance Coverage Research Form

PATIENT AUTHORIZATION

By signing below, I authorize my healthcare providers, pharmacies, health insurers and other programs that provide me with health benefits to disclose my personal health information (including medical records) and insurance information to Auxilium Pharmaceuticals, Inc. and its representatives, agents and contractors (collectively, "Auxilium"), for Auxilium to use and disclose as may be necessary for my treatment and coordination of care, to obtain insurance coverage information and payment for XIAFLEX® (collagenase clostridium histolyticum) (a prescription product manufactured by Auxilium), to conduct reimbursement verifications, make referrals for payment assistance from charitable foundations, and provide me with educational and treatment support services, including treatment reminders and surveys about my treatment with XIAFLEX. I understand that the information to be disclosed hereunder, once shared with others, will not be protected by state and federal privacy laws.

I understand that my pharmacy provider may receive remuneration from Auxilium in exchange for health information and/or for therapy support services provided to me.

I understand that this authorization is voluntary and that, if I do not sign it, my ability to obtain treatment from my physician or other healthcare providers, or to obtain insurance benefits, will not be affected; however, I will not be eligible to receive the services described above from Auxilium. I understand that I may revoke this authorization at any time, to end further use and disclosure of my information, except to the extent that my information has been used or disclosed in reliance upon this authorization, or as permitted by law. I understand that if I choose to revoke this authorization, I must do so in writing to the following address:

XIAFLEX Reimbursement Helpline
c/o Covance Health Market Access Services
PO Box 4280, Gaithersburg, MD 20885-4280

This authorization expires three (3) years from the date of execution, or one (1) year after the date of my last prescription, whichever is later. I am entitled to receive a copy of this authorization.

Patient Signature ____________ **Date** ____

Patient Printed Name ____

Legal Representative ____ **Date** ____

Relationship to Patient ____

PHYSICIAN INFORMATION

Physician Name ____

Physician Specialty ____

Practice Name ____

Practice Address ____

City ____ State ____ Zip ____

NPI # ____ DEA # ____

Tax ID # ____ Medicare PTAN ____

XIAFLEX REMS Healthcare Provider Enrollment ID # ____

XIAFLEX REMS Healthcare Setting Enrollment ID # ____

Contact Person ____

Contact Phone # ____ Fax # ____

Contact Email ____

Access Preference: Buy and Bill ☐ Specialty Pharmacy Shipment ☐

XIAFLEX REIMBURSEMENT HELPLINE

Toll-Free Phone 1-877-XIAFLEX (1-877-942-3539)

Toll-Free Fax 1-877-909-2337

PATIENT INFORMATION

First Name ____ Last Name ____ MI ____

Address ____

City ____ State ____ Zip ____

Daytime Phone # ____ Alternate Phone # ____

Email ____

DOB ____

Primary Insurance ____

(Copy of insurance card[s] acceptable in lieu of completing insurance information below.)

Policy Holder ____ Group # ____

Policy # ____ Provider ID # ____

Insurance Contact ____ Phone # ____

Secondary Insurance (if applicable) ____

Policy Holder ____ Group # ____

Policy # ____ Provider ID # ____

Insurance Contact ____ Phone # ____

CLINICAL INFORMATION*

*Please research benefits assuming 1 vial used or 2 vials used on day of administration

Anticipated Initial Injection Date ____

Number of vials to be used on the above injection date ☐ 1 ☐ 2

Diagnosis: Dupuytren's contracture ICD-9 728.6 ☐ Yes ☐ No

Treatment Setting: ☐ Physician Office ☐ Hospital Outpatient ☐ ASC

Please complete the planned treatment course based upon number of cords per hand:

RIGHT HAND: # of MP joints to treat ____ # of PIP joints to treat ____

Affected finger(s): R2 R3 R4 R5

LEFT HAND: # of MP joints to treat ____ # of PIP joints to treat ____

Affected finger(s): L2 L3 L4 L5

Rx INFORMATION

In New York, please attach all prescriptions on official New York prescription forms.

XIAFLEX (collagenase clostridium histolyticum) 0.9 mg Single-use Vial

Sig: Inject 0.58 mg of XIAFLEX into each of 1 or 2 palpable Dupuytren's cord(s) with a contracture of a metacarpophalangeal (MP) joint or a proximal interphalangeal (PIP) joint. Up to 2 joints in the same hand may be treated during a treatment visit. Injections may be administered up to 3 times per cord at approximately 4-week intervals.

Dispense ☐ 1 vial ☐ 2 vials

Up to 2 joints in the same hand may be treated during a treatment visit.

Refill ☐ times NDC# 66887-003-01

Each vial of XIAFLEX and sterile diluent should only be used for a single injection. If 2 joints on the same hand are to be treated during a treatment visit, separate vials and syringes should be used for each reconstitution and injection.

I appoint the XIAFLEX Reimbursement Helpline, administered by Covance as my agent, to convey on my behalf to the pharmacy the prescription described herein.

____________ **Date** ____

Prescriber Signature Required (no stamps)

☐ Yes ☐ No Request syringes for reconstitution and administration, (1 mL hubless syringe, 0.01 mL graduations, permanently fixed, 27-gauge 1/2" needle)

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