

## **Clinical Policy: Collagenase Clostridium Histolyticum (Xiaflex)**

Reference Number: CP.PHAR.82

Effective Date: 10.01.11

Last Review Date: 08.21

Line of Business: Commercial, HIM, Medicaid

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Collagenase clostridium histolyticum (Xiaflex<sup>®</sup>) is a combination of bacterial collagenases.

### **FDA Approved Indication(s)**

Xiaflex is indicated for the treatment of:

- Adult patients with Dupuytren's contracture (DC) with a palpable cord
- Adult men with Peyronie's disease (PD) with a palpable plaque and curvature deformity of at least 30 degrees at the start of therapy

### **Policy/Criteria**

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Xiaflex is **medically necessary** when the following criteria are met:

#### **I. Initial Approval Criteria**

##### **A. Dupuytren's Contracture (must meet all):**

1. Diagnosis of DC with a palpable cord;
2. Prescribed by or in consultation with a healthcare provider experienced in injection procedures of the hand and in the treatment of DC;
3. Age  $\geq$  18 years;
4. Member has not received surgical treatment (e.g., fasciectomy, fasciotomy) on the selected primary joint within the last 90 days;
5. If two injections (two vials) are requested, they are for one of the following (a or b):
  - a. One cord affecting two joints in the same finger;
  - b. Two cords affecting two joints in the same hand;
6. Dose does not exceed 0.58 mg per injection (one vial per injection).

**Approval duration: 3 months (up to 2 injections)**

##### **B. Peyronie's Disease (must meet all):**

1. Diagnosis of PD with both of the following (a and b):
  - a. Palpable plaque;
  - b. Curvature deformity of  $\geq$  30 degrees at the start of therapy;
2. Prescribed by or in consultation with a healthcare provider experienced in the treatment of male urological diseases;
3. Age  $\geq$  18 years;

4. Dose does not exceed 0.58 mg per injection (one vial per injection).

**Approval duration: 3 months (up to 2 injections)**

**C. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

**II. Continued Therapy**

**A. Dupuytren's Contracture (must meet all):**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Last treatment was  $\geq 4$  weeks ago;
3. Member has not received more than two total injections per affected cord;
4. Request is for one or both of the following:
  - a. Metacarpophalangeal (MP) or proximal interphalangeal (PIP) contracture remains in affected cord since previous injection and the contracture is  $> 5$  degrees;
  - b. A different MP or PIP contracture will be injected;
5. If two injections (two vials) are requested, use is for one of the following (a or b):
  - a. One cord affecting two joints in the same finger;
  - b. Two cords affecting two joints in the same hand;
6. Member has not received surgical treatment (e.g., fasciectomy, fasciotomy) on the selected primary joint within the last 90 days;
7. If request is for a dose increase, new dose does not exceed 0.58 mg per injection (one vial per injection).

**Approval duration: 3 months (up to 2 injections, total of 3 injections per affected cord)**

**B. Peyronie's Disease (must meet all):**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Documented curvature deformity of  $\geq 15$  degrees remaining since last treatment cycle;
3. Last treatment cycle was  $\geq 6$  weeks ago;
4. Member has received  $< 4$  treatment cycles (i.e.  $< 8$  injections [2 injections per cycle]);
5. If request is for a dose increase, new dose does not exceed 0.58 mg per injection (one vial per injection).

**Approval duration: 3 months (up to 2 injections)**

**C. Other diagnoses/indications (must meet 1 or 2):**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

**Approval duration: Duration of request or 3 months (whichever is less); or**



Indication	Dosing Regimen	Maximum Dose
	<p>A treatment course consists of a maximum of 4 treatment cycles. Each treatment cycle consists of two Xiaflex injection procedures and one penile modeling procedure. The second Xiaflex injection procedure is performed 1 to 3 days after the first. The penile modeling procedure is performed 1 to 3 days after the second injection of the treatment cycle. The interval between treatment cycles is approximately six weeks. The treatment course therefore, consists of a maximum of 8 injection procedures and 4 modeling procedures.</p> <p>If the curvature deformity is less than 15 degrees after the first, second or third treatment cycle, or if the healthcare provider determines that further treatment is not clinically indicated, then the subsequent treatment cycles should not be administered.</p> <p>The safety of more than one treatment course of Xiaflex is not known.</p>	

**VI. Product Availability**

Lyophilized powder for reconstitution (single-use glass vials): 0.9 mg of collagenase clostridium histolyticum

**VII. References**

1. Xiaflex Prescribing Information. Malvern, PA: Endo Pharmaceuticals, Inc.; November 2019. Available at <https://www.xiaflex.com/>. Accessed April 12, 2021.
2. Schulze SM and Tursi JP. Postapproval clinical experience in the treatment of Dupuytren’s contracture with collagenase clostridium histolyticum (CCH): the first 1,000 days. *Hand*. 2014; 9: 447-458.
3. Collagenase Drug Monograph. Clinical Pharmacology. Available at: <http://www.clinicalpharmacology-ip.com>. Accessed April 12, 2021.
4. Nehra A, Alterowitz R, Culkin DJ, et al. Peyronie’s Disease: American Urological Association (AUA) Guideline, 2015. Available at: <https://www.auanet.org/guidelines/guidelines/peyronies-disease-guideline>. Accessed May 11, 2021.
5. Manka MG, White LA, Yafi FA, et al. Comparing and Contrasting Peyronie’s Disease Guidelines: Points of Consensus and Deviation. *J Sex Med* 2021; 18: 363-375.

**Coding Implications**

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

<b>HCPCS Codes</b>	<b>Description</b>
J0775	Injection, collagenase, clostridium histolyticum, 0.01 mg

<b>Reviews, Revisions, and Approvals</b>	<b>Date</b>	<b>P&amp;T Approval Date</b>
Converted policy to new template. Removed age limitation and added max dose for both indications.	12.16	01.17
Converted to new template. Dupuytren’s and Peyronie’s: Added age restriction as safety and effectiveness of Xiaflex in pediatric patients < 18 years old have not been established and removed requirement related to history of hypersensitivity to Xiaflex per safety approach. Modified approval duration to allow up to 2 injections within a 3 month period. Peyronie’s disease: Removed requirements related to completion of training for use of Xiaflex and contraindication related to plaques that involve the penile urethra since Xiaflex is available for the treatment of Peyronie’s disease only through Xiaflex REMS program.	08.22.17	11.17
3Q 2018 annual review: Policies combined for Commercial and Medicaid lines of business; HIM – Medical added; Dupuytren’s contracture – removed “table top test” and flexion contracture degree requirements (clinical trial inclusion criteria) as specialist involvement is required; references reviewed and updated.	04.30.18	08.18
3Q 2019 annual review: No significant changes; references reviewed and updated.	04.17.19	08.19
3Q 2020 annual review: no significant changes; revised HIM-Medical Benefit to HIM line of business; references reviewed and updated.	05.12.20	08.20
3Q 2021 annual review: no significant changes; references to HIM.PHAR.21 revised to HIM.PA.154; retire WCG.CP.PHAR.82; references reviewed and updated.	04.12.21	08.21

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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