

XIAFLEX® (collagenase clostridium histolyticum)



HEALTH INSURANCE CLAIM FORM

Medicare Part B Claims

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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| <input type="checkbox"/> PICA | | | | | | | | | | | | <input type="checkbox"/> PICA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. MEDICARE <input type="checkbox"/> (Medicare#) | | | | MEDICAID <input type="checkbox"/> (Medicaid#) | | | | TRICARE <input type="checkbox"/> (ID#/DoD#) | | | | CHAMPVA <input type="checkbox"/> (Member ID#) | | | | GROUP HEALTH PLAN <input type="checkbox"/> (ID#) | | | | FECA BLK LUNG <input type="checkbox"/> (ID#) | | | | OTHER <input type="checkbox"/> (ID#) | | | | 1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123-45-6789A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John Q. | | | | | | | | | | | | 3. PATIENT'S BIRTH DATE MM DD YY: 10 19 1935 | | | | | | | | | | | | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) Same | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. PATIENT'S ADDRESS (No., Street) 1212 Main St. | | | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> | | | | | | | | | | | | 7. INSURED'S ADDRESS (No., Street) Same | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CITY Any City | | | | | | STATE XX | | | | | | 8. RESERVED FOR NUCC USE | | | | | | CITY | | | | | | STATE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ZIP CODE XXXXX | | | | | | TELEPHONE (Include Area Code) (123) 555-1212 | | | | | | ZIP CODE | | | | | | TELEPHONE (Include Area Code) () | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURANCE | | | | | | | | | | | | 10. RESERVED FOR NUCC USE | | | | | | | | | | | | 11. RESERVED FOR NUCC USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURANCE AARP | | | | | | | | | | | | b. RESERVED FOR NUCC USE | | | | | | | | | | | | c. RESERVED FOR NUCC USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE | | | | | | | | | | | | e. RESERVED FOR NUCC USE | | | | | | | | | | | | f. RESERVED FOR NUCC USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 12. PATIENT'S SIGNATURE TO PROCESS BELOW. SIGNED _____ | | | | | | | | | | | | 13. AUTHORIZED SIGNATURE OF SUPPLIER FOR PATIENT AND INSURED INFORMATION. SIGNED _____ | | | | | | | | | | | | 14. DATE OF SERVICE (MM DD YY) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | | | | | | | | | | | 17a. QUAL. | | | | | | | | | | | | 17b. NPI | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | | | | | | | | | | | 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | | | | \$ CHARGES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A. M72.0 | | | | | | | | | | | | B. _____ | | | | | | | | | | | | C. _____ | | | | | | | | | | | | D. _____ | | | | | | | | | | | | E. _____ | | | | | | | | | | | | F. _____ | | | | | | | | | | | | G. _____ | | | | | | | | | | | | H. _____ | | | | | | | | | | | | I. _____ | | | | | | | | | | | | J. _____ | | | | | | | | | | | |
| 24. A. DATE(S) OF SERVICE (From MM DD YY To MM DD YY) | | | | | | | | | | | | B. PLACE OF SERVICE | | | | | | | | | | | | C. EMG | | | | | | | | | | | | D. PROCEDURES, SERVICES, OR SUPPLIES (CPT/HCPCS) | | | | | | | | | | | | E. DIAGNOSIS POINTER | | | | | | | | | | | | F. \$ CHARGES | | | | | | | | | | | | G. DAYS OR UNITS | | | | | | | | | | | | H. EPSDT Family Plan | | | | | | | | | | | | I. ID. QUAL. | | | | | | | | | | | | J. RENDERING PROVIDER ID. # | | | | | | | | | | | |
| 1 10 03 21 10 03 21 11 | | | | | | | | | | | | 11 | | | | | | | | | | | | J0775 | | | | | | | | | | | | A | | | | | | | | | | | | XXX XX 58 | | | | | | | | | | | | NPI | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 5 _____ | | | | | | | | | | | | _____ | | | | | | | | | | | | _____ | | | | | | | | | | | | _____ | | | | | | | | | | | | _____ | | | | | | | | | | | | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6 _____ | | | | | | | | | | | | _____ | | | | | | | | | | | | _____ | | | | | | | | | | | | _____ | | | | | | | | | | | | _____ | | | | | | | | | | | | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. FEDERAL TAX I.D. NUMBER 123456789 | | | | | | | | | | | | SSN EIN | | | | | | | | | | | | 26. PATIENT'S ACCOUNT NO. | | | | | | | | | | | | 27. ACCEPT ASSIGNMENT? (For gov't. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | | | | 28. TOTAL CHARGE \$ XXXX XX | | | | | | | | | | | | 29. AMOUNT PAID \$ | | | | | | | | | | | | 30. Rsvd for NUCC Use XXXX XX | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) | | | | | | | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | | | | | | | | | | 33. BILLING PROVIDER INFO & PH # () | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED _____ | | | | | | | | | | | | DATE _____ | | | | | | | | | | | | a. NPI _____ | | | | | | | | | | | | b. NPI _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

SAMPLE 1500 FORM SINGLE CORD TREATMENT

Based on prior policy, this sample represents how your Medicare Administrative Contractor (MAC) is likely to require completion of claim forms for J0775, and the CPT® codes 20527 and 26341. This sample form is not intended to replace or modify your MAC's policy, and use of this form does not guarantee payment or take the place of professional coding advice. Coding is part of the clinical decision, and each provider is responsible for selecting the billing codes that most accurately describe the services provided and for adhering to all payor guidance. Information is subject to change. Please refer to the policy on the MAC's website. This sample claim form does not represent any clinical or treatment recommendation.

Use JW modifier to indicate how much drug is wasted from single-use vial.

These amounts are provided as an example of the recommended dose and wastage in accordance with the XIAFLEX® Prescribing Information.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Please see Indication and Important Safety Information on next page.

Click for full Prescribing Information and Medication Guide.

MM-05675/January 2022

INDICATION

XIAFLEX® is indicated for the treatment of adult patients with Dupuytren's contracture with a palpable cord.

IMPORTANT SAFETY INFORMATION FOR XIAFLEX

- XIAFLEX is contraindicated in patients with a history of hypersensitivity to XIAFLEX or to collagenase used in any other therapeutic application or application method
- In the controlled and uncontrolled portions of clinical trials in Dupuytren's contracture, flexor tendon ruptures occurred after XIAFLEX injection. Injection of XIAFLEX into collagen-containing structures such as tendons or ligaments of the hand may result in damage to those structures and possible permanent injury such as tendon rupture or ligament damage. Therefore, XIAFLEX should be injected only into the collagen cord with a metacarpophalangeal (MP) or proximal interphalangeal (PIP) joint contracture, and care should be taken to avoid injecting into tendons, nerves, blood vessels, or other collagen-containing structures of the hand. When injecting a cord affecting a PIP joint of the fifth finger, the needle insertion should not be more than 2 to 3 mm in depth and avoid injecting more than 4 mm distal to the palmar digital crease
- Other XIAFLEX-associated serious local adverse reactions in the controlled and uncontrolled portions of the clinical studies included pulley rupture, ligament injury, complex regional pain syndrome (CRPS), sensory abnormality of the hand, and skin laceration (tear). In a historically controlled post-marketing trial, the incidence of skin laceration (22%) was higher for subjects treated with two concurrent injections of XIAFLEX compared with subjects treated with up to three single injections in the placebo-controlled premarketing trials (9%). Post-marketing cases of skin laceration requiring skin graft after finger extension procedures and local skin and soft-tissue necrosis, some requiring skin grafting, or other surgical interventions including finger amputation have been reported. Signs or symptoms that may reflect serious injury to the injected finger/hand should be promptly evaluated because surgical intervention may be required
- In the controlled portions of the clinical trials in Dupuytren's contracture, a greater proportion of XIAFLEX-treated patients (15%) compared to placebo-treated patients (1%) had mild allergic reactions (pruritus) after up to 3 injections. The incidence of XIAFLEX-associated pruritus increased after more XIAFLEX injections in patients with Dupuytren's contracture
- Because XIAFLEX contains foreign proteins, severe allergic reactions to XIAFLEX can occur. Anaphylaxis was reported in a post-marketing clinical trial in one patient who had previous exposure to XIAFLEX for the treatment of Dupuytren's contracture. Healthcare providers should be prepared to address severe allergic reactions following XIAFLEX injections
- In the XIAFLEX trials in Dupuytren's contracture, 70% and 38% of XIAFLEX-treated patients developed an ecchymosis/contusion or an injection site hemorrhage, respectively. Patients with abnormal coagulation (except for patients taking low-dose aspirin, eg, up to 150 mg per day) were excluded from participating in these studies. Therefore, the efficacy and safety of XIAFLEX in patients receiving anticoagulant medications (other than low-dose aspirin, eg, up to 150 mg per day) within 7 days prior to XIAFLEX administration is not known. In addition, it is recommended to avoid use of XIAFLEX in patients with coagulation disorders, including patients receiving concomitant anticoagulants (except for low-dose aspirin)
- In the XIAFLEX clinical trials for Dupuytren's contracture, the most common adverse reactions reported in ≥25% of patients treated with XIAFLEX and at an incidence greater than placebo were edema peripheral (eg, swelling of the injected hand), contusion, injection site hemorrhage, injection site reaction, and pain in the injected extremity. Post-marketing experience – Syncope and presyncope have been reported in patients treated with XIAFLEX for Dupuytren's contracture. In some cases, pain from injection and pain during finger extension procedures were identified as potential triggers for syncopal events

Click for full [Prescribing Information](#) and [Medication Guide](#).