PRIOR AUTHORIZATION for HYPOGLOSSAL NERVE NEUROSTIMULATION

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Member & Provider Services at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

Date Requested:	Name (Last, First MI):	DOB:	Age:	PEHP ID #:

Section II: PROVIDER INFORMATION

***Rendering* Provider:**	***Rendering* Provider Address:**

Provider NPI #:	Provider TIN #:	Contact Person:	Phone:	Facsimile:	Email Address:
			( )	( )	

***Facility/Hospital*:**	***Facility/Hospital* Address:**

Facility NPI #:	Facility TIN #:	Contact Person:	Phone:	Facsimile:	Email Address:
			( )	( )	

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: ***Please check.***
☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth ☐ Urgent

Requested Date of Service:
From: **To:**

Place of Service: ***Please check.***
☐ Ambulatory Surgical Center ☐ Inpatient ☐ Office ☐ Outpatient

Procedure Codes Requested: ***Please list all requested services/CPT codes regardless of pre-auth requirement. Unlisted codes cannot be pre-authorized.***

Procedure/Service: _____ CPT/HCPCS code: _____

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Procedure/Service: _____ CPT/HCPCS code: _____

Primary Diagnosis/ICD-10 Code (s):	**Secondary Diagnosis/ICD-10 Code (s):**

A. Hypoglossal Nerve Neurostimulation Procedure Requested: ***Please check.***
☐ Initial ☐ Removal ☐ Replacement (Array, Electrode, Pulse Generator) ☐ Revision

B. For Removal, Replacement, or Revision Requests:
Date of Initial Implantation: _____

C. Hypoglossal Nerve Neurostimulation Device/System to Be Used: ***Product selection is mandatory.***

1. ☐ Apnex Hypoglossal Nerve Stimulation (HGNS) System
2. ☐ Inspire Medical Systems Inspire® Upper Airway System (UAS)
3. ☐ LiaNova Aura6000™ Neurostimulation System
4. ☐ Nyxoah Genio® System
5. ☐ WellStar Upper Airway Neurostimulation Implant
6. ☐ Other (*please specify*): _____

QUESTION	YES	NO	COMMENTS/NOTES
D. ☐ Diagnostic, Referral, and Contraindication Assessment for Hypoglossal Nerve Stimulation: ***Completion of this section is mandatory.***			
1. Has the patient been diagnosed with moderate to severe obstructive sleep apnea (OSA)?	☐	☐	
2. Was a polysomnography (PSG) performed within 24 months of the first consultation for implantation of a hypoglossal nerve neurostimulator?	☐	☐	***Please submit copy of PSG report.***
3. Did the diagnostic PSG show that the patient had an AHI between 10 and 50 events per hour for patients aged 13 to 18, or an AHI between 15 and 65 events per hour for patients aged 22 or older?	☐	☐	
4. Did a diagnostic PSG show that the patient predominantly had obstructive events, defined as central and mixed apneas comprising less than 25% of the total Apnea-Hypopnea Index (AHI)?	☐	☐	
5. Was the absence of complete concentric collapse at the soft palate level — or the absence of other anatomical abnormalities likely to impair device function (e.g., tonsil size 3 or 4, per the tonsillar hypertrophy grading scale) — confirmed during the drug-induced sleep endoscopy (DISE) procedure?	☐	☐	***Please submit copy of DISE report.***

PEHP Health & Benefits

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QUESTION (*cont'd*)	YES	NO	COMMENTS/NOTES
6. Has the patient been referred for hypoglossal nerve neurostimulator implantation by both a board-certified sleep medicine specialist and a board certified otolaryngologist (Ear, Nose, and Throat [ENT]), unless the provider is board-certified in both specialties?	☐	☐	
7. Has an oral appliance been deemed ineffective in adequately controlling the patient's sleep apnea or determined to be not clinically appropriate for use?	☐	☐	
8. Will implantation of the hypoglossal nerve neurostimulator be performed by a board-certified board certified otolaryngologist (ENT)?	☐	☐	
9. Does the patient have any of the following contraindications to hypoglossal nerve neurostimulator implantation? ***Please check all that apply.*** ☐ History of hypoglossal nerve palsy ☐ Inability to operate the sleep remote ☐ Moderate to severe pulmonary arterial hypertension ☐ Neuromuscular or neurological disease (e.g., muscular dystrophy, Parkinson's disease) that compromises neurological control of the upper airway ☐ New York Heart Association class III or IV heart failure ☐ Other implantable device that may be susceptible to unintended interaction with the Inspire UAS system ☐ Persistent uncontrolled hypertension ☐ Pregnancy or plans to become pregnant ☐ Recent myocardial infarction or severe cardiac arrhythmias (within the past 6 months) ☐ Severe restrictive or obstructive pulmonary disease ☐ Severe valvular heart disease	☐	☐	
E. ☐ Hypoglossal Nerve Neurostimulation for Adolescents: ***Completion of Section D is also required.***			
1. Does the patient have Down Syndrome (Trisomy 21)?	☐	☐	
2. Is the patient between the ages of 13 and 18?	☐	☐	
3. Is the patient's Body Mass Index (BMI) at or below the 95th percentile for their age? **Current BMI: _____ Percentile for Age: _____ Date: _____**	☐	☐	
4. Has the member made a documented and legitimate attempt to use first-line continuous positive airway pressure (CPAP) therapy within the past 24 months, supported by verifiable objective compliance data and comprehensive clinical documentation?	☐	☐	***Please submit copy of CPAP usage.***
4.a Has the member demonstrated CPAP compliance, defined as attempted usage on at least 70% of nights during a consecutive 30-day period within the most recent 90 days?	☐	☐	
4.b Has CPAP failure or intolerance been documented, defined as failure or inability to use the CPAP device due to physical discomfort, psychological factors (e.g., claustrophobia), or side effects (e.g., dry mouth and nose, eye irritation, headaches, nasal congestion, skin irritation), despite appropriate troubleshooting and attempts to improve compliance?	☐	☐	
5. Has the patient undergone an adenotonsillectomy?	☐	☐	
5.a If *yes*, was the adenotonsillectomy ineffective in treating the obstructive sleep apnea (OSA)?	☐	☐	
5.b If *no*, was the patient not a candidate for an adenotonsillectomy?	☐	☐	
6. Has the standard of care been followed in considering all alternative and adjunct therapies for obstructive sleep apnea (OSA)?	☐	☐	
F. ☐ Hypoglossal Nerve Neurostimulation for Adults: ***Completion of Section D is also required.***			
1. Is the patient 22 years old or older?	☐	☐	
2. Is the patient's Body Mass Index (BMI) less than 32 kg/m2? **Current BMI: _____ Date: _____**	☐	☐	
3. Has the member made a documented and legitimate attempt to use first-line continuous positive airway pressure (CPAP) therapy within the past 24 months, supported by verifiable objective compliance data and comprehensive clinical documentation?	☐	☐	***Please submit copy of CPAP usage.***
3.a Has the member demonstrated CPAP compliance, defined as attempted usage on at least 70% of nights during a consecutive 30-day period within the most recent 90 days?	☐	☐	

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QUESTION (*cont'd*)	YES	NO	COMMENTS/NOTES
3.b Has CPAP failure or intolerance been documented, defined as failure or inability to use the CPAP device due to physical discomfort, psychological factors (e.g., claustrophobia), or side effects (e.g., dry mouth and nose, eye irritation, headaches, nasal congestion, skin irritation), despite appropriate troubleshooting and attempts to improve compliance?	☐	☐	
3.c Has the patient undergone a documented trial of at least three different CPAP mask types (e.g., nasal cradle, nasal-oral hybrid, nasal pillow, standard full face, under-the-nose full face) to help confirm intolerance to CPAP therapy, especially if the patient reports issues such as claustrophobia, mask discomfort, poor fit, pressure-related discomfort, or skin irritation?	☐	☐	
G. ☐ Hypoglossal Nerve Neurostimulator Removal:			
1. Is the removal indicated because there has been a change in clinical condition, such as complete resolution or significant improvement of obstructive sleep apnea (OSA) following interventions like substantial weight loss, or the emergence of new contraindications to device use (e.g., neuromuscular disorders, clinically significant arrhythmias, or electromagnetic interference from implanted devices)?	☐	☐	
2. Is the removal indicated because the patient has experienced device-related complications, such as localized or systemic infection refractory to medical management, mechanical or electrical malfunction uncorrectable by reprogramming or surgery, or skin erosion, device migration, or extrusion of any implanted component?	☐	☐	
3. Is the removal indicated because there is evidence of insufficient therapeutic response, demonstrated by a documented lack of clinically meaningful improvement after adequate therapy duration with appropriate device settings, and persistent moderate to severe obstructive sleep apnea on follow-up polysomnography despite adherence and optimized stimulation?	☐	☐	
4. Is the removal indicated because the patient is experiencing intolerance or adverse effects, such as significant impairment in functioning or quality of life, or refractory stimulation-induced pain or discomfort not resolved by device reprogramming or conservative interventions?	☐	☐	
H. ☐ Hypoglossal Nerve Neurostimulator Replacement: ***Completion of Sections D and E (adolescents) or Section F (adults) is also required.***			
1. Is the device no longer under warranty?	☐	☐	
2. Does the member meet the established criteria for implantation of a hypoglossal nerve neurostimulator?	☐	☐	
3. Is the replacement indicated as part of clinically appropriate management of device-related complications, such as infection or other adverse events involving implanted hardware?	☐	☐	
4. Is the replacement indicated for irreparable device failure, characterized by malfunction of internal electronic circuitry or structural component degradation that cannot be corrected through surgical revision or device reprogramming?	☐	☐	
5. Is the replacement indicated due to battery depletion or a clinically meaningful decline in device function confirmed by device interrogation, including reduced stimulation output, increased impedance, or failure to maintain appropriate stimulation parameters?	☐	☐	
6. Is the replacement necessary to preserve safe and effective device operation when the existing system is no longer supported by the manufacturer or has performance limitations compromising therapeutic efficacy?	☐	☐	
I. ☐ Hypoglossal Nerve Neurostimulator Revision: ***Completion of Sections D and E (adolescents) or Section F (adults) is also required.***			
1. Is the revision indicated because there is a device-related complication (e.g., pain, pressure, or erosion) that is localized and correctable through revision?	☐	☐	
2. Is the revision indicated because there is an inadequate stimulation response due to lead positioning or impedance issues, as confirmed by device interrogation?	☐	☐	
3. Is the revision indicated because a lead or device migration has occurred, resulting in suboptimal stimulation or loss of therapeutic effect?	☐	☐	
4. Is the revision indicated because there is a partial mechanical failure that can be corrected without full device replacement?	☐	☐	
Additional Comments:			

By submitting this form, I attest that the information provided is true and accurate to the best of my knowledge.

Please fax completed form and medical records to 801-366-7449.