

PRIOR AUTHORIZATION for INTERVERTEBRAL DISC PROSTHESES

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 #:
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Section II: PROVIDER INFORMATION

Rendering Provider:	Rendering Provider Address:
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Provider NPI #:	Provider TIN #:	Contact Person:	Phone: ()	Facsimile: ()	Email Address:
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Facility/Hospital:	Facility/Hospital Address:
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Facility NPI #:	Facility TIN #:	Contact Person:	Phone: ()	Facsimile: ()	Email Address:
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Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: <i>Please check.</i>	Requested Dates of Service: From: _____ To: _____	Place of Service: <i>Please check.</i> <input type="checkbox"/> Ambulatory Surgical Center <input type="checkbox"/> Inpatient <input type="checkbox"/> Office <input type="checkbox"/> Outpatient
Primary Diagnosis/ICD-10 Code:	Secondary Diagnosis/ICD-10 Code:	

Service (s) Requested: *Please list all requested services regardless of pre-authorization requirement. Unlisted codes cannot be pre-authorized.*

Service Description: _____	CPT/HCPCS: _____

<i>(Please check service being requested.)</i>	QUESTION	YES	NO	COMMENTS/NOTES
A. <input type="checkbox"/> Artificial Cervical Disc Replacement:				
1. Does the patient have symptomatic cervical disc degeneration or herniation at a level(s) between C3 and C7?	<input type="checkbox"/>	<input type="checkbox"/>		
2. Is the patient skeletally mature?	<input type="checkbox"/>	<input type="checkbox"/>		
3. Have other possible causes of the pain and/or neurological deficit been ruled out (e.g., congenital spinal abnormalities, infection, malignancy, muscle strain, thoracic outlet syndrome)?	<input type="checkbox"/>	<input type="checkbox"/>		
4. Does the patient have signs and/or symptoms consistent with neural compression (e.g., myelopathy, neurogenic claudication, radiculopathy) at the level(s) being treated?	<input type="checkbox"/>	<input type="checkbox"/>		
5. Is chronic neck pain or cervicobrachialgia causing significant impairment?	<input type="checkbox"/>	<input type="checkbox"/>		
6. Is diagnostic imaging (e.g. CT or MRI) consistent with the subjective (e.g., arm and neck pain radiating down the arm, numbness and/or tingling in the arm) and objective findings (e.g., muscle weakness, reduced cervical range of motion)?	<input type="checkbox"/>	<input type="checkbox"/>	<i>Please submit imaging reports</i>	
6.a. Does diagnostic imaging show nerve root compression or spinal cord compression?	<input type="checkbox"/>	<input type="checkbox"/>		
6.b. Does diagnostic imaging reveal moderate, moderate-to-severe, or severe central, lateral recess, or foraminal stenosis at the level of planned cervical disc implantation (<i>Note: Severe bilateral stenosis is excluded from coverage</i>)?	<input type="checkbox"/>	<input type="checkbox"/>		
7. Did the patient fail to respond to at least six (6) weeks of conservative/non-surgical therapies (e.g., non-opioid and opioid oral analgesics, physical therapy) under the direction of a medical professional within the past twelve (12) months?	<input type="checkbox"/>	<input type="checkbox"/>		
8. Is the involved vertebral endplate appropriate for the dimensions of the implant?	<input type="checkbox"/>	<input type="checkbox"/>		
9. Will any of the following FDA approved artificial cervical disc arthroplasty devices be used? <i>*Product selection is required.</i>				
<input type="checkbox"/> Bryan Cervical Disc	<input type="checkbox"/> M6-C Cervical Disc	<input type="checkbox"/> ProDisc-C SK		
<input type="checkbox"/> Prestige Cervical Disc	<input type="checkbox"/> PCM (Porous Coated Motion)	<input type="checkbox"/> ProDisc-C Vivo Total Disc Replacement		
<input type="checkbox"/> Prestige LP Cervical Disc	<input type="checkbox"/> ProDisc-C	<input type="checkbox"/> Secure-C Artificial Cervical Disc		
<input type="checkbox"/> Mobi-C	<input type="checkbox"/> ProDisc-C Novo	<input type="checkbox"/> Simplify Cervical Artificial Disc		
10. Does the patient have any contraindications to cervical artificial disc replacement? <i>*Completion of Section D. is required.</i>	<input type="checkbox"/>	<input type="checkbox"/>		
11. Is the artificial cervical disc replacement planned at two noncontiguous levels?	<input type="checkbox"/>	<input type="checkbox"/>		
12. Would implantation of another artificial cervical disc result in more than two (2) contiguous disc replacement levels?	<input type="checkbox"/>	<input type="checkbox"/>		

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Name (Last, First MI):	DOB:	Age:	PEHP ID #:		
(Please check service being requested.)		QUESTION (cont'd)		YES	NO
B. <input type="checkbox"/> Artificial Lumbar Disc Replacement:					
1. Is the patient between the ages of 18 and 60 years old?				<input type="checkbox"/>	<input type="checkbox"/>
2. Is the patient skeletally mature?				<input type="checkbox"/>	<input type="checkbox"/>
3. Does diagnostic imaging (e.g., CT or MRI) performed within the previous six (6) months confirm degenerative disc disease (DDD) at a single lumbar level?				<input type="checkbox"/>	<input type="checkbox"/>
4. Does the member have degenerative disc disease at a single lumbar level at L3-4, L4-5, or L5-S1 per FDA-approved indications?				<input type="checkbox"/>	<input type="checkbox"/>
5. Has the member failed to respond to at least six (6) months of conservative/non-surgical therapies (e.g., non-opioid and opioid oral analgesics, in-person physical therapy combined with a home exercise program) under the direction of a medical professional within the past twelve (12) months?				<input type="checkbox"/>	<input type="checkbox"/>
6. Does the member have moderate to severe pain, with a Visual Analog Score greater than 5 on a scale of 0 to 10?				<input type="checkbox"/>	<input type="checkbox"/>
7. Is the involved vertebral endplate appropriate for the dimensions of the implant?				<input type="checkbox"/>	<input type="checkbox"/>
8. Will any of the following FDA approved artificial lumbar disc arthroplasty devices be used? *Product selection is required. <input type="checkbox"/> activL Artificial Lumbar Disc System <input type="checkbox"/> Prodisc-L Total Disc Replacement				<input type="checkbox"/>	<input type="checkbox"/>
9. Does the patient have any contraindications to lumbar artificial disc replacement? *Completion of Section D. is required.				<input type="checkbox"/>	<input type="checkbox"/>
10. Will lumbar artificial disc replacement be done with fusion at adjacent levels (hybrid spine surgery)?				<input type="checkbox"/>	<input type="checkbox"/>
C. <input type="checkbox"/> Replacement or Revision of Artificial Cervical or Lumbar Disc Replacement: *Completion of Section A. or B. and D. is also required.					
1. Does imaging studies (e.g. CT or MRI) confirm that the implanted disc has had mechanical failure or an associated complication (e.g., disc dislodgement, disc breakage, disc infection, disc loosening, disc migration, vertebral body fracture)?				<input type="checkbox"/>	<input type="checkbox"/>
2. Was the initial artificial cervical or lumbar disc replacement performed using an FDA-approved device, and in accordance with those approved indications?				<input type="checkbox"/>	<input type="checkbox"/>
3. Were the symptoms of lumbar degenerative disc disease (DDD) or herniated disc partially or fully alleviated by the initial artificial cervical or lumbar disc replacement, but persistent or recurrent symptoms have reoccurred and are directly attributable to failure of the implanted disc?				<input type="checkbox"/>	<input type="checkbox"/>
D. <input type="checkbox"/> Contraindications to Artificial Cervical and Lumbar Disc Replacement: *Completion of this section is required for all requests.					
1. Does the patient have any of the following contraindications to artificial cervical or lumbar disc replacement? Please check all that apply.				<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Active malignancy involving the spine at the level of planned disc implantation <input type="checkbox"/> Active systemic infection or infection localized to the site of implantation <input type="checkbox"/> Allergy or sensitivity to the implant materials (e.g., cobalt, chromium, molybdenum, polyethylene, titanium) <input type="checkbox"/> Damaged or compromised vertebral bodies at the level of planned disc implantation secondary to: 1) congenital abnormalities affecting the vertebrae or disc space; 2) current or previous spine trauma (e.g., fracture); 3) significant anatomical deformity; or 4) systemic inflammatory arthropathy (e.g., ankylosing spondylitis, lupus, psoriatic arthritis, rheumatoid arthritis) <input type="checkbox"/> Isolated radicular compression syndrome (single nerve root is compressed or irritated) due to bony spinal stenosis that requires extensive decompression involving removal of facets or laminae that would destabilize the segment <input type="checkbox"/> Marked spinal instability or segmental instability <input type="checkbox"/> Pars interarticularis defect <input type="checkbox"/> Poor bone quality due to osteoporosis or osteopenia (e.g., T-score less than or equal to negative 1.0) <input type="checkbox"/> Prior spinal fusion or other surgery that destabilized the spine (e.g., facetectomy, laminectomy) at the level to be treated <input type="checkbox"/> Severe <i>bilateral</i> central, lateral recess, and/or foraminal stenosis at the level of disc implantation <input type="checkbox"/> Severe facet disease (e.g., facet ankylosis, facet arthropathy, facet degeneration) at the level of disc implantation <input type="checkbox"/> Symptomatic disc degeneration or herniation beyond the proposed surgical site				<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient have any of the following contraindications specific to artificial lumbar disc replacement? Please check all that apply.				<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Abdominal pathology that may prohibit an anterior retroperitoneal approach <input type="checkbox"/> Lumbar scoliosis with greater than 11 degrees of sagittal plane deformity (front-to-back curve of the spine)				<input type="checkbox"/>	<input type="checkbox"/>
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.					