PRIOR AUTHORIZATION for PANNICULECTOMY

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

Ordering/Rendering Provider:	*Ordering/Rendering* Provider Address:

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

Facility/Hospital:	*Facility/Hospital* Address:

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

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.*	Requested Date(s) of Service:	Place of Service: *Please check.*
☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth ☐ Urgent	From: To:	☐ Ambulatory Surgical Center ☐ Inpatient ☐ Office ☐ Outpatient

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

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

Service Description: _____ CPT/HCPCS: _____

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QUESTION	YES	NO	COMMENTS/NOTES
1. Does the patient have a Grade 1 – 5 panniculus according to the American Society of Plastic Surgeons (ASPS) grading system? ***Please check.*** ☐ **Grade 1:** Panniculus covers hairline and mons pubis, but not the genitals ☐ **Grade 2:** Panniculus covers genitals and upper thigh crease ☐ **Grade 3:** Panniculus covers upper thigh ☐ **Grade 4:** Panniculus covers mid-thigh ☐ **Grade 5:** Panniculus covers knees and below	☐	☐	*Please submit (frontal & side-view) pre-operative photographs taken in a standing position.*
2. Does the pannus cause functional physical impairment that interferes with activities of daily living (ADLs)—such as dressing, meal preparation, household chores, and occupational responsibilities—and is surgical intervention expected to restore or improve this deficit?	☐	☐	
3. Has at least three months of medical treatment—including antifungals, corticosteroids, and dressing changes—failed to resolve chronic complications from excess skin folds, such as infections, ulcerations, or tissue breakdown?	☐	☐	
4. Does the member have a documented history of at least one episode of cellulitis that required systemic antibiotic or antifungal therapy administered orally or intravenously?	☐	☐	
5. Has there been a significant amount of weight loss (approximately 14 BMI points or achieving a BMI ≤ 30)? **Current Height:** _____ **Staring Weight (lbs):** _____ **Current Weight (lbs):** _____ **Weight Lost (lbs):** _____ **Starting BMI:** _____ **Current BMI** _____	☐	☐	
5.a Has the patient maintained a stable weight—fluctuating no more than 5 to 10 pounds—over the past 6 months?	☐	☐	
5.b Did the patient achieve weight loss through bariatric surgery? **Date of Surgery:** _____ **Type of Bariatric Surgery:** *Please check all that apply.* ☐ Adjustable Gastric Banding ☐ Duodenal Switch with Biliopancreatic Diversion ☐ Roux-en-Y Gastric Bypass ☐ Sleeve Gastrectomy	☐	☐	*If no, skip 5.c and 5.d.*
5.c Did the patient undergo weight loss surgery approved through the PEHP Bariatric Surgery Pilot Program or covered under a PEHP employer group health plan that includes bariatric surgery benefits?	☐	☐	
5.d Has it been at least 18 months since the patient had bariatric surgery?	☐	☐	

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