# PRIOR AUTHORIZATION for CRANIAL ORTHOTIC DEVICES

**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 Customer Service at (801) 366-7555 or toll free at (800) 753-7490.**

## Section I: PATIENT INFORMATION

| Name (Last, First MI): | DOB: | Age: | PEHP ID #: |
|---|---|---|---|
| | | | |

## Section II: PROVIDER INFORMATION

| | | | |
|---|---|---|---|
| Date Requested: | | Ordering Provider: | |
| Ordering Provider NPI #: | Ordering Provider Tax ID#: | Ordering Provider Address: | |
| Ordering Provider Contact Person: | Phone: ( ) | Facsimile: ( ) | |
| Service Provider: | Service Provider NPI #: | Service Provider Tax ID #: | Service Provider Address: |
| Service Provider Contact Person: | Phone: ( ) | Facsimile: ( ) | |

## Section III: PRE-AUTHORIZATION REQUEST

| **Nature of Request:** *Please check.* ☐ Pre-Authorization ☐ Retrospective Authorization ☐ Urgent | **Requested Date of Service:** |
|---|---|
| **Primary Diagnosis/ICD-10 Code:** | **Secondary Diagnosis/ICD-10 Code:** |

**Type of Device being requested:** *Please check.*

☐ Custom Molded/Fitted Cranial Orthotic Device/Cranial Remodeling Band or Helmet (HCPCS code S1040): *Please check* ☐ Initial ☐ Replacement ☐ Subsequent
☐ Protective Helmet (HCPCS code A8000 – A8004)

**Service/Durable Medical Equipment (DME) Requested**:

Service/DME Description: _____ CPT/HCPCS code: _____ ☐ Purchase ☐ Rental ☐ Replacement
Service/DME Description: _____ CPT/HCPCS code: _____ ☐ Purchase ☐ Rental ☐ Replacement
Service/DME Description: _____ CPT/HCPCS code: _____ ☐ Purchase ☐ Rental ☐ Replacement

| *(Please check device being requested.)* **QUESTION** | **YES** | **NO** | **COMMENTS/NOTES** |
|---|---|---|---|
| **A.** ☐ **Custom Molded/Fitted Cranial Orthotic Device (*S1040/Cranial Remolding Orthosis*):** | | | |
| 1. Is device being requested for treatment of synostotic plagiocephaly (i.e. craniosynostosis) following surgical correction? *Date of Surgery:* _____ | ☐ | ☐ | |
| 2. Is device being requested for treatment of moderate to severe nonsynostotic plagiocephaly? | ☐ | ☐ | |
| 2. a. Is the child either between the age of three and five months and has failed to respond to a two-month trial of repositioning therapy or between the age of six months to 18 months? | ☐ | ☐ | |
| 2. b. Does the patient have a cranial asymmetry with a cephalic index that is ± at least two standard deviations from the mean for the appropriate gender/age? | ☐ | ☐ | |
| 2. c. Does the patient have a cranial asymmetry of 12mm or more in cranial vault, skull base, or orbitotragial depth? | ☐ | ☐ | |
| 3. Has the patient undergone surgical symmetry correction for synostotic plagiocephaly? | ☐ | ☐ | |
| 4. Will device be used preoperatively for the treatment of sagittal craniosynostosis? | ☐ | ☐ | |
| 5. Does the patient have unshunted or uncontrolled hydrocephalus? | ☐ | ☐ | |
| **B.** ☐ **Replacement of Custom Molded/Fitted Cranial Orthotic Device:** | | | |
| 1. Is the current device not usable or functional because of misuse, abuse, or neglect? | ☐ | ☐ | |
| **C.** ☐ **Subsequent Custom Molded/Fitted Cranial Orthotic Device:** | | | |
| 1. Is subsequent device being requested for growth change accommodation? | ☐ | ☐ | |
| 2. Was the initial device determined to be medically necessary? | ☐ | ☐ | |
| 3. Does significant cranial asymmetry persist? | ☐ | ☐ | |
| 4. Is further meaningful improvement expected with continued use of the cranial orthotic device? | ☐ | ☐ | |

**Additional Comments:**

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