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 #:

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.*	Requested Dates 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:	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: _____

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(Please check service being requested.) QUESTION	YES	NO	COMMENTS/NOTES
A. ☐ Artificial Cervical Disc Replacement:			
1. Does the patient have symptomatic cervical disc degeneration or herniation at a level(s) between C3 and C7?	☐	☐	
2. Is the patient skeletally mature?	☐	☐	
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)?	☐	☐	
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?	☐	☐	
5. Is chronic neck pain or cervicobrachialgia causing significant impairment?	☐	☐	
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)?	☐	☐	***Please submit imaging reports***
6.a. Does diagnostic imaging show nerve root compression or spinal cord compression?	☐	☐	
6.b. Does diagnostic imaging demonstrate central canal, lateral recess, or foraminal stenosis that is classified as moderate or worse (i.e., moderate, moderate-to-severe, or severe) rather than mild?	☐	☐	
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?	☐	☐	
8. Is the involved vertebral endplate appropriate for the dimensions of the implant?	☐	☐	
9. Will any of the following FDA approved artificial cervical disc arthroplasty devices be used? ***Product selection is required.*** ☐ Bryan Cervical Disc ☐ M6-C Cervical Disc ☐ ProDisc-C SK ☐ Prestige Cervical Disc ☐ PCM (Porous Coated Motion) ☐ ProDisc-C Vivo Total Disc Replacement ☐ Prestige LP Cervical Disc ☐ ProDisc-C ☐ Secure-C Artificial Cervical Disc ☐ Mobi-C ☐ ProDisc-C Novo ☐ Simplify Cervical Artificial Disc	☐	☐	
10. Does the patient have any contraindications to cervical artificial disc replacement? ***Completion of Section D. is required.***	☐	☐	
11. Is the artificial cervical disc replacement planned at two noncontiguous levels?	☐	☐	
12. Would implantation of another artificial cervical disc result in more than two (2) contiguous disc replacement levels?	☐	☐	

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

(Please check service being requested.) QUESTION (*cont'd*)	YES	NO	COMMENTS/NOTES
B. ☐ Artificial Lumbar Disc Replacement:			
1. Is the patient between the ages of 18 and 60 years old?	☐	☐	
2. Is the patient skeletally mature?	☐	☐	
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?	☐	☐	***Please submit imaging reports***
4. Does diagnostic imaging demonstrate severe bilateral central, lateral recess, and/or foraminal stenosis at the level planned for lumbar disc implantation?	☐	☐	
5. Does the member have degenerative disc disease at a single lumbar level at L3-4, L4-5, or L5-S1 per FDA-approved indications?	☐	☐	
6. 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?	☐	☐	
7. Does the member have moderate to severe pain, with a Visual Analog Score greater than 5 on a scale of 0 to 10?	☐	☐	
8. Is the involved vertebral endplate appropriate for the dimensions of the implant?	☐	☐	
9. Will any of the following FDA approved artificial lumbar disc arthroplasty devices be used? ***Product selection is required.*** ☐ activL Artificial Lumbar Disc System ☐ Prodisc-L Total Disc Replacement	☐	☐	
10. Does the patient have any contraindications to lumbar artificial disc replacement? ***Completion of Section D. is required.***	☐	☐	
11. Will lumbar artificial disc replacement be done with fusion at adjacent levels (hybrid spine surgery)?	☐	☐	
C. ☐ 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)?	☐	☐	***Please submit imaging reports***
2. Was the initial artificial cervical or lumbar disc replacement performed using an FDA-approved device, and in accordance with those approved indications?	☐	☐	
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?	☐	☐	
D. ☐ 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.*** ☐ Active malignancy involving the spine at the level of planned disc implantation ☐ Active systemic infection or infection localized to the site of implantation ☐ Allergy or sensitivity to the implant materials (e.g., cobalt, chromium, molybdenum, polyethylene, titanium ☐ 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) ☐ 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 ☐ Marked spinal instability or segmental instability ☐ Pars interarticularis defect ☐ Poor bone quality due to osteoporosis or osteopenia (e.g., T-score less than or equal to negative 1.0) ☐ Prior spinal fusion or other surgery that destabilized the spine (e.g., facetectomy, laminectomy) at the level to be treated ☐ Severe facet disease (e.g., facet ankylosis, facet arthropathy, facet degeneration) at the level of disc implantation ☐ Symptomatic disc degeneration or herniation beyond the proposed surgical site	☐	☐	
2. Does the patient have any of the following contraindications specific to artificial lumbar disc replacement? ***Please check all that apply.*** ☐ Abdominal pathology that may prohibit an anterior retroperitoneal approach ☐ Lumbar scoliosis with greater than 11 degrees of sagittal plane deformity (front-to-back curve of the spine)	☐	☐	

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.