PRIOR AUTHORIZATION for BREAST SURGERY

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(S) 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 Date 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:**

☐ **History of Lumpectomy and/or Mastectomy:** ☐ **N/A**

1. Date(s) of Surgery: _____ 2. Side of lumpectomy and/or mastectomy (***please check***): ☐ Bilateral ☐ Left ☐ Right
3. Indication (***please check all that apply***):
   a. ☐ Breast Cancer (☐ *Bilateral* ☐ *Left* ☐ *Right)*
   b. ☐ Prophylactic (☐ *Bilateral* ☐ *Left* ☐ *Right)*
   c. ☐ Other (***please specify***): _____

Type of Breast Surgery Being Requested: ***Please check all that apply.***

1. ☐ Areolar Reconstruction or Tattooing
2. ☐ Nipple Reconstruction or Tattooing
3. ☐ Augmentation Mammoplasty
4. ☐ Autologous Fat Graft via Liposuction
5. ☐ Autologous Fat Graft using Adipose-Derived Stem Cells
6. ☐ Body Lift Perforator Flap
7. ☐ Breast Implant Removal
8. ☐ Breast Implant Removal & Subsequent Reimplantation
9. ☐ Breast Reduction by Mammoplasty or Mastopexy
10. ☐ Capsulectomy
11. ☐ Capsulotomy
12. ☐ Deep Inferior Epigastric Perforator (DIEP)
13. ☐ Gluteal Artery Perforator (GAP) * ***Noncovered***
14. ☐ Implantation of Breast Prosthesis
15. ☐ Implantation of Tissue Expander
16. ☐ Latissimus Dorsi (LD) Myocutaneous Flap
17. ☐ Oncoplastic Reconstruction
18. ☐ Prophylactic Mastectomy
19. ☐ Reconstructive Surgical Revision
20. ☐ Ruben's Flap
21. ☐ Superficial Inferior Epigastric Artery (SIEA) Flap * ***Noncovered***
22. ☐ Superficial Inferior Epigastric Perforator (SIEP) Flap
23. ☐ Superior or Inferior Gluteal Free Flap
24. ☐ Transverse Rectus Abdominus Myocutaneous (TRAM) Flap
25. ☐ Transverse Upper Gracilis (TUG) Flap
26. ☐ Vascularized Lymph Node Transfer (VLNTx)
27. ☐ Xenograft Cartilage Grafting
28. ☐ Other (***please specify***): _____

☐ **For Breast Implant Removal/Breast Implant Removal with Subsequent Reimplantation Requests:** ☐ **N/A**

1. Initial indication for insertion of breast implant(s): ***Please check all that apply.***
   a. ☐ Augmentation/Cosmetic b. ☐ Breast Cancer (***please check***): ☐ Bilateral ☐ Left ☐ Right
   c. ☐ Other (***please specify***): _____
2. Side for breast implant removal with or without subsequent reimplantation (***please check***): ☐ Bilateral ☐ Left ☐ Right
3. Indication for implant removal: ***Please check all that apply.***
   a. ☐ Baker Class III or IV contracture
   b. ☐ Breast implant-associated anaplastic large cell lymphoma
   c. ☐ Extra-capsular rupture of saline implant and the rupture has compromised the cosmetic outcome of the implant
   d. ☐ Extrusion of implant through the skin
   e. ☐ Implants complicated by recurrent infections
   f. ☐ Implants with severe contracture that interferes with mammography
   g. ☐ Intra- or extra-capsular rupture of silicone gel-filled implants
   h. ☐ Remnant breast cancer or cancer in the contralateral breast

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

☐ **For Prophylactic Mastectomy Requests:** ☐ **N/A**

1. Is the patient high risk for hereditary breast cancer? ☐ Yes ☐ No
   a. Did the patient test positive for BRCA1, BRCA2, CDH1, PALB2, PTEN, STK11, or TP53 gene mutations?
   b. Does the patient have a high-risk histology: Atypical ductal or lobular hyperplasia, or lobular carcinoma in situ confirmed on biopsy?
   c. Does the patient have such extensive mammographic abnormalities (e.g., calcifications, cystic/dense breast tissue) that adequate biopsy is impossible?
   d. Does the patient have a personal history of breast cancer making it more likely to develop a new cancer in the opposite breast?
   e. Did the patient receive radiation therapy to the thoracic region between 10 and 30 years of age?
   f. Does the patient have a lifetime risk of 20% or greater of developing breast cancer as identified by Gail or Claus after negative mutation testing?

☐ **For Breast Reduction (Mammaplasty) Requests:** ☐ **N/A**

1. Patient's Height (cm): _____ Patient's Weight (kg): _____ Total Body Surface Area (BSA): _____
2. Indication for reduction (***please check/complete***):
   a. ☐ Reduction on nondiseased/contralateral breast for symmetry following mastectomy or lumpectomy
   b. ☐ Symptomatic macromastia with anticipated weight of tissue to be removed: ***Left Breast***_____ **gm** ***Right Breast***_____ **gm**
   c. ☐ Other (***please specify***): _____

☐ **For Breast Reconstruction Requests:** ☐ **N/A**

1. Side for breast reconstruction (***please check***): ☐ Bilateral ☐ Left ☐ Right
2. Indication for reconstruction (***please check all that apply***): a. ☐ Implant Failure b. ☐ Symmetry c. ☐ Unsatisfactory Breast Reconstruction
   d. ☐ Other (***please specify***): _____

☐ **For Products to be used with Breast Reconstruction Requests:** ***Please check all that apply.*** *****PEHP approved product for use in breast reconstruction.*** ☐ **N/A**

1. ☐ AlloDerm® (HCPCS Q4116 / CPT 15777) **
2. ☐ BellaDerm Acellular Hydrated Dermis
3. ☐ Biodesign® Nipple Reconstruction Cylinder (CPT 19350)
4. ☐ Cortiva® (*formerly marketed as AlloMax™/ NeoForm™*) (HCPCS C1781 / C5271-C5274 / Q4100)
5. ☐ DermACELL® (HCPCS Q4122 / CPT 15777) **
6. ☐ DermACELL ® AWM (HCPCS Q4122 / CPT 15777) **
7. ☐ DermaMatrix Acellular Dermis (HCPCS C1781 / Q4100)
8. ☐ FlexHD® Acelluar Hydrated Dermis (HCPCS Q4128 / CPT 15777) **
9. ☐ hMatrix® (HCPCS Q4134)
10. ☐ Permacol® (HCPCS C9364 / Q4110)
11. ☐ Phasix Mesh
11. ☐ Radiesse® (HCPCS Q2026)
12. ☐ Repriza® (HCPCS C5271-C5274 / Q4143)
13. ☐ Strattice™ (HCPCS C1781 / Q4130)
14. ☐ SurgiMend® (HCPCS C5271-C5274 / C9358 / C9360)
15. ☐ Other (***please specify***) _____

Please Note: ***PEHP limits coverage of breast implants to the size of the woman's natural breast size and skin substitutes to dimensions that will cover the woman's breast based on the women's natural breast size and the manufacturer's recommendations. PEHP requires documentation of the woman's cup size and expected dimensions for the skin substitute. Excessive billing of skin substitutes will be denied. Specification of the number of units/expected dimensions for skin substitutes is mandatory.***

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

Surgery/Description: _____ CPT/HCPCS: _____ ☐ Bilateral ☐ Left ☐ Right

Surgery/Description: _____ CPT/HCPCS: _____ ☐ Bilateral ☐ Left ☐ Right

Surgery/Description: _____ CPT/HCPCS: _____ ☐ Bilateral ☐ Left ☐ Right

Surgery/Description: _____ CPT/HCPCS: _____ ☐ Bilateral ☐ Left ☐ Right

Surgery/Description: _____ CPT/HCPCS: _____ ☐ Bilateral ☐ Left ☐ Right

Skin Substitute Product: _____ **CPT/HCPCS:** _____**Natural Breast/Cup Size:** _____ **# of Units/Dimensions Required:** _____

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.***