PRIOR AUTHORIZATION for WOUND CARE

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

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

Section II: PROVIDER INFORMATION

***Rendering* Provider:**	**Provider NPI #:**	**Provider Tax ID #:**	**Provider Address:**
***Rendering* Provider Contact Person:**	**Contact Person Phone:** ( )	**Contact Person Facsimile:** ( )	**Contact Person Email:**
***Facility* Name:**	**Facility NPI #:**	**Facility Tax ID #:**	**Facility Address:**
***Facility* Contact Person:**	**Contact Person Phone:** ( )	**Contact Person Facsimile:** ( )	**Contact Person Email:**

Section III: PRE-AUTHORIZATION REQUEST

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

Primary Diagnosis/ICD-10 Code:	**Secondary Diagnosis/ICD-10 Code:**
Are services related to a motor vehicle accident? ☐ Yes ☐ No Date of Accident: _____	**Are services related to a work-related injury?** ☐ Yes ☐ No Date of Injury: _____

A. ☐ **For Hyperbaric Oxygen Therapy (HBOT):** **** Completion of this section is mandatory if service being requested.*** ☐ **N/A**

1. **Type of HBOT (*please check*):** ☐ Systemic (Full Body) ☐ Topical
2. **Indication for HBOT (*please specify/describe*):** _____
3. **Type of Request (*please check*):** ☐ Initial / # of treatments being requested: _____ ☐ Additional / # of treatments being requested: _____
4. **Additional Comments:** _____

B. ☐ **For Negative Pressure Wound Therapy (NPWT):** **** Completion of this section and Section D. is mandatory if service being requested.*** ☐ **N/A**

1. **Brand/Name of Device being Requested:** _____
2. **Type of NPWT being requested (*please check*):**
   - **a.** ☐ Disposable/Mechanical NPWT (*e.g., SNAP Therapy*) **b.** ☐ Electrical NPWT Pump **c.** ☐ Single-Use NPWT Device (*e.g., Prevena Incision Management*)
3. **Type of Request (*please check*):** ☐ Initial ☐ Authorization Extension (*Initial Start Date:* _____)
4. **Additional Comments:** _____

C. ☐ **For Skin Grafts / Skin Substitute Grafts:** **** Completion of this section and Section D. is mandatory if service being requested.*** ☐ **N/A**

1. **Type of Skin Graft (*please check*):** ☐ Autologous ☐ Allogeneic Human Cadaver-Derived ☐ Allogeneic Pig Skin Derived ☐ Skin Substitute
2. **Name of Skin Substitute Product:** _____
   - **a. Type of Application (*please check*):** ☐ Initial Application ☐ Additional Applications *(# of additional applications being requested:* _____)
   - **b. # Of Units Per Application:** _____ **Total # of Units Requested:** _____ **Smallest Size Available to Provider:** _____
3. **To verify adequate blood supply, are pedal pulses palpable or is the Ankle-Brachial Index (ABI) ≥ 0.70?** ☐ No ☐ Yes
4. **Current hemoglobin A1C (HbA1C) for patients with type I or type II Diabetes Mellitus:** Date: _____ Result: _____
5. **Additional Comments:** _____

PRIOR AUTHORIZATION for WOUND CARE

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

D. ☐ **Wound Profile(s):** **** Completion of this section is mandatory if service is related to wound management.*** ☐ **N/A**

1. **Wound Profile #:** _____ **Location:** _____ **Side:** ☐Bilateral ☐Left ☐Right ☐N/A

a. **How long has the wound been present?** _____

b. **Drainage Amount (*please check*):** ☐None ☐Scant ☐Minimal ☐Moderate ☐Heavy/Copious

c. **Wound Type (*check all that apply*):**

☐Burn ☐Dehiscence ☐Diabetic Foot Ulcer ☐Pressure Ulcer ☐Surgical ☐Traumatic ☐Venous Stasis Ulcer ☐Other_____

d. **Wound Thickness (*check all that apply*):** ☐Deep ☐Full ☐Partial ☐Stage I ☐Stage II ☐Stage III ☐Stage IV ☐Superficial ☐Unstageable

e. **Previous failed treatment(s):** _____

f. **Treatment being requested (*check all that apply*):** ☐ HBOT ☐NPWT ☐Skin Grafting ☐Other _____

g. **INITIAL Date / Measurements (centimeter/cm):** _____

Length _____ *Width* _____ *Depth* _____ *Square Centimeter* (cm^2)_____ *Tunneling* _____ *Undermining* _____

h. **CURRENT Date / Measurements (cm):** _____

Length _____ *Width* _____ *Depth* _____ *Square Centimeter* (cm^2)_____ *Tunneling* _____ *Undermining* _____

---

2. **Wound Profile #:** _____ **Location:** _____ **Side:** ☐Bilateral ☐Left ☐Right ☐N/A

a. **How long has the wound been present?** _____

b. **Drainage Amount (*please check*):** ☐None ☐Scant ☐Minimal ☐Moderate ☐Heavy/Copious

c. **Wound Type (*check all that apply*):**

☐Burn ☐Dehiscence ☐Diabetic Foot Ulcer ☐Pressure Ulcer ☐Surgical ☐Traumatic ☐Venous Stasis Ulcer ☐Other_____

d. **Wound Thickness (*check all that apply*):** ☐Deep ☐Full ☐Partial ☐Stage I ☐Stage II ☐Stage III ☐Stage IV ☐Superficial ☐Unstageable

e. **Previous failed treatment(s):** _____

f. **Treatment being requested (*check all that apply*):** ☐ HBOT ☐NPWT ☐Skin Grafting ☐Other _____

g. **INITIAL Date / Measurements (centimeter/cm):** _____

Length _____ *Width* _____ *Depth* _____ *Square Centimeter* (cm^2)_____ *Tunneling* _____ *Undermining* _____

h. **CURRENT Date / Measurements (cm):** _____

Length _____ *Width* _____ *Depth* _____ *Square Centimeter* (cm^2)_____ *Tunneling* _____ *Undermining* _____

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

Service: _____ CPT: _____ HCPCS: _____ ☐Bilateral ☐Left ☐Right

Service: _____ CPT: _____ HCPCS: _____ ☐Bilateral ☐Left ☐Right

Service: _____ CPT: _____ HCPCS: _____ ☐Bilateral ☐Left ☐Right

Service: _____ CPT: _____ HCPCS: _____ ☐Bilateral ☐Left ☐Right

Service: _____ CPT: _____ HCPCS: _____ ☐Bilateral ☐Left ☐Right

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.***