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 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(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:**

A. ☐ **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***): _____

B. 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) *
14. ☐ Implantation of Breast Prosthesis
15. ☐ Implantation of Tissue Expander
16. ☐ Latissimus Dorsi (LD) Myocutaneous Flap
17. ☐ Oncoplastic Reconstruction
18. ☐ Reconstructive Surgical Revision
19. ☐ Ruben's Flap
20. ☐ Superficial Inferior Epigastric Artery (SIEA) Flap *
21. ☐ Superficial Inferior Epigastric Perforator (SIEP) Flap
22. ☐ Superior or Inferior Gluteal Free Flap
23. ☐ Transverse Rectus Abdominus Myocutaneous (TRAM) Flap
24. ☐ Transverse Upper Gracilis (TUG) Flap
25. ☐ Vascularized Lymph Node Transfer (VLNTx)
26. ☐ Xenograft Cartilage Grafting
27. ☐ Other (***please specify***): _____

DIEP, GAP, and SIEA procedures not covered effective 07/01/23.

C. ☐ **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. ☐ Side of 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 #:

D. ☐ **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***): _____

E. ☐ **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***): _____

F. ☐ **For Products to be used with Breast Reconstruction Requests:** ***Please check all that apply.*** ☐ **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) *** *EFF 07/01/24*
6. ☐ DermACELL ™ AWM (HCPCS Q4122 / CPT 15777) *** *EFF 07/01/24*
7. ☐ DermaMatrix Acellular Dermis (HCPCS C1781 / Q4100)
8. ☐ FlexHD Acelluar Hydrated Dermis (HCPCS Q4128 / CPT 15777) *** *EFF 07/01/24*
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***) _____

*** PEHP approved product for use in breast reconstruction. Specification of the number of units required is mandatory in section G.***

G. 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

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

Product Name: _____ CPT/HCPCS: _____ **Number of Units (*per 0.5 or 1.0 sq cm*) Required:** _____

Product Name: _____ CPT/HCPCS: _____ **Number of Units (*per 0.5 or 1.0 sq cm*) Required:** _____

Product Name: _____ CPT/HCPCS: _____ **Number of Units (*per 0.5 or 1.0 sq cm*) 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.